BROOK HOUSE PUBLIC INQUIRY

WRITTEN CLOSING SUBMISSIONS ON BEHALF OF
G4S CARE AND JUSTICE (UK) LIMITED
AND G4S HEALTH SERVICES (UK) LIMITED

Introduction

1. These written closing submissions are drafted on behalf of G4S Care and Justice Services (UK) Limited ("G4S CJS") and G4S Health Services (UK) Limited ("G4S Health") (collectively "G4S"). G4S has set out its position in the corporate evidence of Mr Brockington (for G4S CJS) and Mr Dove (for G4S Health). Additionally, the Inquiry has been provided with detailed witness statements and lengthy oral evidence from a number of senior G4S CJS staff in place during the Relevant Period including Mr Petherick, Mr Neden and Mr Hanford. In relation to Healthcare, the Inquiry received evidence from Ms Calver, Ms Churcher and Ms Williams who were all in place during the Relevant Period. These closing submissions do not repeat this extensive evidence which the Inquiry will no doubt take careful account of.

2. After a summary of G4S's case, these closing submissions begin with short sections on the procedural fairness of the Inquiry[1] and general submissions on the reliability of certain witnesses.[2] This is followed by introductory submissions on Brook House Immigration Removal Centre ("Brook House") and the challenges faced by G4S during the Relevant Period.[3] The next section of the closing submissions will address various key issues in

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[1] See paragraphs 10-21

[2] See paragraphs 22-40

[3] See paragraphs 41-61

relation to the custodial care[4] and healthcare.[5] The final two sections will address Article 3 ECHR[6] and the 53 "incidents of concern" detailed in the Inquiry's spreadsheet provided to Core Participants.[7] The latter section is by far the longest as it is clear from May J's judgment in *R (MA and BB) v Secretary of State for the Home Department* [2019] EWHC 1529 (Admin), the terms of reference and the determination of scope, that the focus of the inquiry is into the acts of deliberate abuse such as those shown in the Panorama programme rather than the conditions of detention generally.[8]

Summary

3. G4S accept that a number of its staff at Brook House engaged in mistreatment of detainees. Further, a number of staff witnessed such mistreatment but did not report it. Both the mistreatment of the detainees and the failure, by other staff who were present, to intervene to stop it or, to report it was wholly inappropriate, and abhorrent to G4S; such misconduct[9] was fundamentally inconsistent with G4S's values and what was expected of their employees.

4. G4S repeat its apology made in both its oral opening and closing submissions. Mr Gordon Brockington on behalf of G4S made clear that it was "*exceptionally sorry*"[10] 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*"[11] 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*".[12] Mr Jerry

[4] See paragraphs 62-140

[5] See paragraphs 141-192

[6] See paragraphs 193-250

[7] See paragraphs 251-662

[8] See, in particular, the Notice of Determination, Inquiry Scope, paragraphs 12-16

[9] "Misconduct" in this document is used colloquially to mean conduct that was unacceptable rather than treatment contrary to Article 3 ECHR

[10] Mr Brockington, 31 March 2022, 35/24

[11] Mr Neden, 22 March 2022, 47/2-3

[12] Mr Neden, 22 March 2022, 56/22-24

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.

5. Because of the failure by staff who witnessed this misconduct to report it, either to senior members of staff or via the "Speak Out" whistleblowing channel, G4S was unaware of such misconduct at the time and was not able to intervene to stop it. Of course, it was not just G4S who was unaware of the mistreatment of detainees. Both the Home Office and the Independent Monitoring Board had a permanent presence at Brook House but neither organisation was aware of the mistreatment notwithstanding their important independent monitoring roles.[13] Further, HM Chief Inspector of Prisons, in his January 2017[14] report, published shortly before the Relevant Period, did not identify any such mistreatment. The Report described the inspection as *"encouraging"* and noted improvement since the last inspection and concluded that Brook House was *"reasonably good"* on all four healthy establishment tests.

6. When the mistreatment of detainees came to light as a result of the Panorama programme, G4S took swift action and disciplined and dismissed the employees responsible for this misconduct. Whilst the mistreatment of detainees by a small minority of G4S staff was shocking, none of the treatment breached Article 3 ECHR and its prohibition of inhumane, degrading treatment and torture.[15]

7. As a result of the terms of reference, the focus of the Inquiry, and the evidence heard by the Inquiry, is inevitably on the shocking mistreatment of detainees by a small minority of staff; not a holistic assessment of the performance of any individual staff member, of G4S or any other contractor, or the Home Office. However, it is important to bear in mind that such mistreatment (and the selective footage recorded by Mr Tulley) was not reflective of the vast majority of interactions between staff and detainees during the Relevant Period which were characterised by respect and dignity. Ms Syred, who, as set out below, was a credible witness, was keen to emphasize this in both his written and his oral evidence. In his oral closing submissions, Mr Syred summarised the position as follows:

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[13] IMB0000135_0004: *"We [ie the IMB] have never witnessed instances of ill-treatment of this kind, nor have we had any indications that it might be happening."*

[14] CJS000761

[15] As set out below at paragraphs 193-203, the Inquiry cannot, in any event, lawfully make findings as to whether there has been a breach of Article 3 ECHR. The role of Inquiries is to make factual (as opposed to legal) findings and to make recommendations

> "The Inquiry has seen and heard about the worse of Brook House but there is also another side which was not shown in Panorama or drawn out in the inquiry hearings. It 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.
> ....
> Mr Syred can recall numerous examples of caring and supportive behaviour by staff, such as a welfare office colleague, Nikki Madgwick, who arranged for a detained person's dog to be cared for by a canine charity; James Begg, safer custody manager, who provided detained persons with his contact number so that they could contact him 24/7 if they had thoughts of self-harm; Ramon Giraldo, a highly respected and well liked colleague who worked tirelessly to provide activities for detained persons with the limited resources available to him; Michelle Brown, who attended Surrey Accident and Emergency with an Egyptian national who required specialist treatment for mental health issues and stayed at hospital all night to support him; and Mr Syred's colleagues in welfare, who all went the extra mile on a daily basis."[16]
>
> (emphasis added)

8. Mr Syred's comments accord with the findings in the 2017 report on Brook House from Her Majesty's Chief Inspector of Prisons which stated:

> "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. We saw staff dealing with a range of issues with resilience and even-handedness. Many staff integrated will with detainees…"[17]

9. Mr Syred's evidence and the HMIP Report accurately record the position: the majority of G4S staff during the Relevant Period did a good job and looked after the detainees. They felt a true 'duty of care' towards detained persons: not simply in the legal sense, but in the practical and moral sense, too.

[16] Closing Statements, 5 April 2022, 170/9-181/1

[17] CJS000761_0015, para S16

Procedural fairness

Introduction

10. Whilst the procedure and conduct of the Inquiry is for the Chair to determine,[18] she must act fairly.[19] Unfortunately, the procedure adopted by the Inquiry has not met the basic requirements of fairness. Prior to the Inquiry starting, the Chair's press interviews raised real concerns that the Inquiry had predetermined various issues. The conduct of the Inquiry further reinforced such concerns. In particular, the differential approaches to questioning of witnesses depending, inter alia, on whether they supported the Chair's views set out in the press interviews is particularly troubling. The approach adopted by the Inquiry of essentially only testing evidence that did not accord with the Chair's predetermined views, is a further reason why it should not reach conclusions on whether or not particular conduct was contrary to Article 3 ECHR.

Apparent bias/predetermination

11. G4S has already raised the issue of apparent bias/predetermination in correspondence with the Inquiry.[20] The concern arises from various press interviews that the Chair gave prior to the commencement of the Inquiry. The articles in *The Guardian* and *The Independent*, if they accurately record what the Chair said, give rise to the appearance of bias/predetermination.

12. *The Independent* article, published on 22 November 2021, states:

> "Systemic issues" in the UK's immigration detention system are likely to be behind the abuse scandal at Brook House removal centre four years ago, the chair of the inquiry into what happened at the facility has said."
> (emphasis added)

13. Similarly, in a *Guardian* article reporting an interview with the Chair that took place in April 2020, the Chair is recorded as telling *a Guardian* journalist:

> "Although things will have moved on at Brook House, which won't be run by the same organisation and things will have changed in the interim, there will be systemic issues that lead to learnings that are applicable elsewhere."
> (emphasis added)

[18] Inquiries Act 2005, 17(1)

[19] Inquiries Act 2005, 17(3)

[20] See G4S's letters of 24 November 2021 and 3 December 2021

14. The use of the word *"will"* in the latter quote, strongly suggests that the Chair has reached a conclusion on the existence of systemic issues at Brook House before hearing any evidence at the Inquiry. The Chair appears to be seeking to justify the existence of the Inquiry on the basis that she will find that systemic issues caused the abuse at Brook House and that such findings will inform other detention settings. Such language strongly suggests the existence of the appearance of bias/predetermination, see *Porter v Magill* [2002] 2 AC 357, para 102 per Lord Hope.

15. Given G4S's concerns, it asked the Chair about what she said in these interviews and requested that she obtain transcripts as such transcripts are necessary to understand precisely what was said. This is an appropriate first step prior to issuing a judicial review claim alleging the appearance of bias, see by analogy *El Farargy v El Farargy* [2007] EWCA Civ 1149, para 32 and *Jones v DAS Legal Expenses Insurance Co Ltd* [2003] EWCA Civ 1071. However, the Chair informed G4S that she did not have a transcript and refused to obtain one from the journalists concerned. In the absence of such transcripts, it is impossible for G4S to form a final view as to the existence of apparent bias/predetermination although the text of the newspapers strongly suggests the existence of such apparent bias/predetermination.

Differential approach of questioning

16. As the Inquiry progressed, it became increasingly clear of an obvious differential treatment of witnesses giving live evidence – via the matter in which witnesses were being questioned which discloses fundamental unfairness to them and also reflects the Inquiry approaching witness evidence having predetermined conclusions, rather than the open mind required (or at least gave the appearance of the same).

17. Witnesses who give evidence: (a) suggestive that there was not a 'toxic culture' at Brook House; (b) that individual incidents that the Inquiry is investigating were justified and/or that mistreatment did not occur; and/or (c) is not generally critical of the operation and management of Brook House during the Relevant Period are far more likely to be treated as 'hostile' by CTI and thus subject to cross-examination rather than being asked open questions. Such treatment as 'hostile' and subject to cross examination rather than open questions was not limited to the DCOs/DCMs accused of mistreatment but included Dr Hard whose conclusions, in his two reports did not fully accord with the Inquiry's predetermined views.

18. Given that the core participants were not permitted to ask questions directly of witnesses, the approach adopted by CTI is very problematic. The Inquiry is inquisitorial in nature; CTI acts on its behalf in adducing and eliciting evidence from witnesses and is required to act with the impartiality and open mind also required of the Chair during the evidence-gathering process. What is therefore impermissible, is for CTI to treat one category of witnesses or evidence pointing in one direction differently from another. Whilst G4S accept that CTI did not treat all such witnesses who were unsupportive of the Inquiry's predetermined view in a hostile fashion on all occasions, a clear pattern has emerged, demonstrating hostility to evidence which is not critical of Brook House management or its staff; or which suggests that mistreatment either did not occur or is not as serious as has been suggested by others. Such differential treatment provides further evidence of predetermination on the part of the Inquiry.

19. By way of example of how that concerning conduct has manifested, in response to Rule 10 requests, G4S were told that: *"CTI will not ask specific questions, which are framed as cross examination."* As pointed out above, the manner in which questions are asked is primarily a matter for CTI and, as a result, the approach to G4S's Rule 10 requests would not be problematic if CTI adopted a consistent position of not asking questions of witnesses which are *"framed as cross examination"* – by which we understand and mean, putting a 'case' or factual proposition to a witness, particularly where it differs from that witness' account. However, it is clear beyond doubt, that CTI frequently cross-examined numerous 'hostile' witnesses. This differential approach and the fact that only one 'side of the case' has been tested means that the it is difficult, if not impossible, for the Inquiry to reach fair conclusions on the factual matters that it is required to determine.

<u>Refusal to ask the vast majority of G4S's Rule 10 questions</u>

20. In the first tranche of the Inquiry, G4S adduced a reasonable number of Rule 10 questions of the various witnesses including Mr Tulley, Reverend Ward, D1618 and D1851. The Inquiry refused to ask the vast majority (over 90%) of G4S's Rule 10 questions even if they were clearly relevant. Indeed, at times, the Inquiry having said that a question was not relevant, it asked similar questions, albeit from a different viewpoint, on the same topic. Numerous questions were rejected because the Chair took the view that the form of the question was inappropriate or amounted to cross examination. Of the questions that were

asked, often CTI asked the question in a way to undermine G4S's case. It became clear that G4S could achieve nothing meaningful from carefully formulated Rule 10 questions.

21. As a result, G4S concluded that asking Rule 10 questions was essentially futile and therefore only asked a very few questions (less than 10) in the second tranche of hearings. G4S understands that the Home Office also concluded that, given the hostile approach adopted by the Inquiry, it was pointless asking Rule 10 questions as they would invariably not be asked or asked in a manner designed to undermine their case.

Witnesses

Introduction

22. The Inquiry has heard from a very large number of witnesses over the nine weeks. Inevitably some of the evidence given by the various witnesses has been inconsistent and contradictory. The Inquiry will need to determine which witnesses are reliable and which witnesses are not on a particular point. Below, G4S make brief submissions on the weight to be placed on various witnesses. It is important to note that, as detailed above, the approach adopted by CTI to questioning varied considerably depending on whether they regarded the witness as supportive of their assumptions and preconceptions as to what happened at Brook House during the Relevant Period. This differential approach impacts on the weight that can be placed on the evidence of the witnesses.

The former detainees who did not give evidence

23. Unfortunately, the majority of former detainees did not give oral evidence to the Inquiry. It is particularly unfortunate, that neither D687 nor D1527, whose judicial review claim led to the setting up of the Inquiry, felt able to give any oral evidence. G4S of course do not criticise the former detainees for this failure but, in the absence of any testing, however gentle, of their evidence by CTI (and indirectly by the core participants via the Rule 10 process) little weight can be placed on their written witness statements without independent corroboration. It is clear that the mere fact that a former detainee has asserted that something happened does not mean that it did happen. D390, who in his witness statement asserted that they had been beaten with batons during a particular incident when, it was clear, from footage played of that incident that this was not the case.

The former detainees who did give evidence

24. Only five former detainees gave oral evidence; three in the first tranche of hearings and two in the second tranche. The majority of these detainees did not give direct evidence in relation to any of the 53 incidents of concern. Indeed, there has been no oral evidence from former detainees in relation to 51 out of 53 of such incidents. As detailed above, the Inquiry's refusal to properly test the evidence of former detainees or ask reasonable questions proposed by G4S means great care should be taken before placing any weight on such evidence.

The various DCOs/DCMs

25. The Inquiry heard from a large number of witnesses who had been employed as DCOs or DCMs during the Relevant Period. The vast majority of such witnesses were accused of mistreatment or a failure to report mistreatment that they witnessed. In such circumstances, it is unsurprising that that they sought to blame others, particularly G4S, for their own serious failures, for example, by reference to the level of staffing at Brook House. The Inquiry should treat such evidence with considerable caution given its self-serving nature.

Mr Callum Tulley

26. As with the various other witnesses whose evidence was consistent with the Inquiry's preconceptions, Mr Tulley was mainly subject to very gentle questioning. Like the other "prosecution witnesses", his evidence was broadly untested. G4S are disappointed that Mr Tulley did not feel able to report the mistreatment that he witnessed either to a member of the senior management team or via G4S's independent whistleblowing "Speak Out" (which was of course confidential) as he was required to do under his contract of employment and under the law. If he had done so, G4S would have been able to put a stop the mistreatment of detainees at an earlier stage. However, G4S accept that as a junior DCO, it is perhaps not surprising that Mr Tulley did not feel able to report such matters and he bears far less responsibility that the more senior members of staff who witnessed such misconduct but also failed to report it.

27. However, it is important to bear in mind that given that Mr Tulley was tasked with making an undercover documentary about mistreatment of detainees at Brook House, his filming was inevitably selective. He needed to obtain footage that would make interesting viewing

and support the premise of the programme. He had no reason to film the vast majority of respectful and caring interactions between staff and detainees referred to in Mr Syred's evidence. This should always be borne in mind when considering his evidence.

Mr Owen Syred

28. Unlike virtually all of the other DCM/DCO witnesses, Mr Syred did not have an agenda; he was not subject to any allegations of misconduct. Unlike the various DCM/DCOs accused of misconduct, he was not trying to minimise responsibility by seeking to blame others. He is clearly a man of integrity who cared about his job and the detainees at Brook House. He had worked at Brook House for a number of years and therefore had a good understanding of the detention centre and its challenges. He provided a far more balanced and accurate view of Brook House during the Relevant Period than the DCMs/DCOs with agendas, Reverend Ward and Mr Tulley. Whilst Mr Syred was very critical of Brook House and/or G4S in relation to a number of issues, he also certain issues he provided a more balanced and accurate portrayal of what Brook House was actually like during the Relevant Period.

Reverend Nathan Ward

29. Reverend Ward was not employed at Brook House during the Relevant Period. As he makes clear in his first witness statement, his employment with G4S ended on 31 May 2014. He is thus unable to give any direct evidence on matters that occurred during the Relevant Period (or indeed during the 3 years that preceded the Relevant Period). During the period of his employment, his involvement with Brook House was limited. Between January 2011 and July 2012, he was "Head of Children's Services at Gatwick IRC" but as Brook House only accommodated adults this role did not lead Reverend Ward to work in Brook House.[21] From July 2012 to 31 May 2014 he was Head of Tinsley House which, as the Inquiry is well aware, is separate from Brook House and caters for a very different population. Whilst in his role as Head of Tinsley House, Reverend Ward had some limited involvement in Brook House, he was not part of the day to day management there whatever he suggested. His knowledge of events at Brook House during this time (ie before 31 May 2014) was necessarily limited.

30. Notwithstanding this, he was granted core participant status on the basis that, *"Rev. Ward was employed by G4S at Brook House during the Relevant Period."* He was thus granted

[21] Other than possibly "age disputed" young persons

core participant status on a false basis. It is not clear why the Inquiry were of the view that Reverend Ward was employed *"during the Relevant Period"*. It may be he misled the Inquiry as to his employment history. If this is the case, such a false statement would fundamentally undermine his credibility. If this is the case, no weight should be placed upon any of his evidence unless it is independently corroborated by either contemporaneous documents or another witness.

31. However, even if this is not the case and the error was that of the Inquiry rather than Reverend Ward, great care should be taken with his evidence as he purports to give evidence on matters about which he has absolutely no direct knowledge. His "evidence" frequently amounts to a commentary on documentary evidence that he has gained access to on the basis of his erroneous elevation to core participant status or documentation that he has obtained utilising the Freedom of Information Act 2000. For example, the Reverend Ward exhibits various documents relating to the 2008 Home Office procurement of a contract to run Brook House. Reverend Ward purports to give evidence on the procurement process although he has no knowledge or expertise as to procurement processes and had absolutely no involvement, direct or otherwise, in the procurement process.

32. Reverend Ward also purports to give evidence about G4S's contractual performance and profits. The basis of this evidence again is not Reverend Ward's involvement in the contract delivery but his analysis of a document (the 360 Degree Contract Review).[22] As Mr Petherick explained when asked about Reverend Ward's evidence he had misunderstood the evidence.[23] Indeed, it was notable, that when Rev Ward's "evidence" on matters were put to witnesses who did have direct involvement, they consistently explained that his understanding or evidence was mistaken. This was the case not just with G4S witnesses but also others.

33. As with the Medical Justice witnesses, Reverend Ward's evidence was, to a great extent, non-expert opinion evidence which would be inadmissible in civil litigation because it is inherently unreliable and has no real probative value. In such circumstances, little or no weight should be placed on Reverend Ward's witness evidence unless it is supported by documentary evidence or other witnesses who do have direct knowledge of such matters.

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[22] CJS000768

[23] Mr Petherick, 21 March 2022, 57/15-59/25

Mr Petherick, Mr Neden and Mr Hanford

34. G4S suggests that all three of the senior G4S management witnesses were credible and honest witnesses whose evidence can be relied upon. All three witnesses fairly accepted where there had been deficiencies during the Relevant Period and recognised where G4S had, on occasion, let down detainees. In such circumstances, the Inquiry should place considerable weight on their evidence.

The Medical Justice witnesses

35. The Inquiry heard oral evidence from two Medical Justice witnesses: Dr Bingham and Ms Schleicher. The Inquiry has also been provided with witness statements from other Medical Justice witnesses including Ms Ginn, the Director of Medical Justice. G4S submits that care should be taken with their evidence. The majority of their evidence did not relate to factual matters about which they are able to give direct evidence. The majority of the evidence from the Medical Justice witnesses, both oral and in writing, amounts to comment and opinion evidence on medical and clinical issues and documents which they had no role in drafting. However, the Medical Justice witnesses are not expert witnesses let alone independent expert witnesses. Medical Justice is a campaigning organisation which seeks the end of immigration detention.[24] They were not instructed by the Inquiry to give their expert opinion and are not subject to the various obligations imposed on expert witnesses. For example, Dr Hard, along with the other expert witnesses instructed by the Inquiry, in their statement of truth, stated that *"the opinions I have expressed represent my true and complete professional opinions on the matters to which they refer."* No such similar declaration appeared in the Medical Justice witnesses yet all of them purported to give opinion evidence on medical and clinical matters. If such evidence had been adduced in civil litigation, it is likely that the majority of it would be inadmissible as non-expert opinion evidence. The reasons for this inadmissibility is that such evidence has limited probative value given that the witness is not subject to the various onerous obligations imposed on expert witnesses and has an interest in the outcome (ie they have a particular viewpoint/agenda).

[24] Emma Ginn ws BHM000041_0057, para 157. G4S do not criticise Medical Justice for holding such a position. However, the fact that Medical Justice are pursuing such an agenda is relevant to the weight that should be placed on their evidence.

36. G4S, of course, accept that the Civil Procedural Rules do not apply to public inquiries held under the Inquiries Act 2005 and that such evidence can be considered by the Inquiry.[25] However, notwithstanding its strict admissibility, G4S submits the Inquiry should treat such evidence with great care as such evidence is of limited probative value given the lack of objectivity of the opinion evidence and the absence of a declaration that the opinions are the true and complete professional opinions.

Dr Hard

37. Dr Hard was appointed as the independent medical expert to assist the Inquiry. His overriding duty was to the Inquiry: unlike the Medical Justice witnesses, he is not pursuing a particular agenda. He was appointed presumably because of his expertise on the provision of healthcare in the custodial environment. He produced two lengthy and balanced reports[26] which included a significant number of positive conclusions about healthcare provision at Brook House including that:

(a) The day to day management of healthcare staff within Brook House was adequate during the relevant period;[27]

(b) The relationships between healthcare and other entities in Brook House were adequate: they were not dysfunctional;[28]

(c) Healthcare staff employed during the relevant period were appropriately qualified;[29]

(d) Rule 34 was being complied with as the required assessment was being carried out consistently;[30]

(e) The overall extent and suitability of the health provision was adequate during the relevant period;[31]

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[25] See section 17(1) inquiries Act 2005

[26] See INQ000057 and INQ000112

[27] INQ000075_0152-154 (para 6.1.1) and INQ000112_0013

[28] INQ000075_0155-156 (para 6.1.2) and INQ000112_0013-0015

[29] INQ000112_0016

[30] INQ000075_0170 (para 6.2.2.8) and INQ000112_0013

[31] INQ000075_0179 (para 6.3.1.3) and INQ000112_0017-18

(f) Any deficiencies in healthcare provision did not directly result in the mistreatment of detained persons.[32]

38. As a significant number of Dr Hard's conclusions did not accord with the Inquiry's preconceived ideas, Dr Hard was subject to wholly inappropriate cross examination where CTI put propositions to him based upon (sometimes inaccurate) summaries of evidence from other witnesses. A significant amount of such evidence came from Medical Justice witnesses who were not independent expert witnesses (see above) but individuals purporting to give opinion evidence to support a particular agenda (ie that immigration detention should cease).[33] As a result, a large proportion of Dr Hard's oral testimony amounted to single word answers (ie "yes") in response to lengthy leading questions from CTI. Such an approach was not designed to elicit Dr Hard's expert opinion (which did not accord with the Inquiry's preconceived views) but to put words into his mouth which, on occasion, contradicted his considered expert opinion as set out in his two lengthy reports. Such cross examination is particularly problematic in light of the fact that the Inquiry rejected numerous Rule 10 questions on the basis that they amounted to (impermissible) cross examination.[34]

39. The approach taken to Dr Hard's evidence can be contrasted with that taken to the two other expert witnesses instructed by the Inquiry: Professor Bosworth and Mr Collier. Both of these experts were, to a great extent, asked open questions and given an opportunity to give their expert opinion. They were not repeatedly told what to think and asked to agree with lengthy propositions based on a purported summary of other witnesses' evidence. In such circumstances, more weight should be placed on Dr Hard's written evidence and his oral evidence should be treated with caution as such "evidence" is not, to a great extent, Dr Hard's evidence but the opinions of CTI with which he was told to agree.

Ms Calver, Ms Churcher and Ms Williams

40. G4S suggests that all three of its healthcare witnesses were credible and honest witnesses whose evidence can be relied upon. All three witnesses fairly accepted where there had been deficiencies in healthcare during the Relevant Period and in particular in relation to Rule 35

[32] INQ000112_0009

[33] See paragraphs 35-36 above

[34] See eg the response to the first Rule 10 question proposed by G4S to Mr James Wilson: "*The Chair does not agree to this specific witness being put to the witness as it is framed as cross-examination.*"

although they also detailed areas of good practice. In such circumstances, the Inquiry should place considerable weight on their evidence.

Relevant background

Introduction

41. Before setting out G4S's submissions on the custodial and healthcare issues together with its response on the 53 "incidents of concern", it is necessary to address first, the relevant factual background. Of course, such background matters including the fundamentally unsuitable building and the very challenging nature of the detainee population, do not – in any way at all – justify or excuse any mistreatment of detained persons by staff. However, such matters 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.

Brook House Immigration Removal Centre

42. Brook House is, 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 and its location only 200 metres from one of Gatwick's runways with the associated noise further increased the oppressive and stressful environment.

43. The fundamental problems with the building have been recognised by a number of witnesses and various bodies. For example, the IMB in its report for 2016 noted, that there was a "*noticeable shortage of space for activities*".[35] A significant number of witnesses referred to challenges arising from the physical architecture of Brook House. Such concerns were echoed by Professor Bosworth who stated in her initial expert report:

> "The design of Brook House Immigration Removal Centre is inappropriate for its purpose. The half doors of showers are undignified, while the toilets in the bedrooms and the inability to open the windows create unpleasant

[35] IMB000121_0006

> living spaces. Men on the footage report that their living spaces became uncomfortably hot in the summer months. These claims are reinforced by details in the IMB minutes. There is limited access to natural light and outdoor space as well as only a small area for activities…The restrictions of a Category B prison make no sense for those held under Immigration Act powers. They make the delivery of a humane and supportive regime very difficult."[36] (emphasis added)

44. Professor Bosworth, on visiting Brook House in 2019, commented that, *"the negative impact of the building's restricted design remained."*[37] In her oral evidence to the Inquiry Professor Bosworth developed this point stating:

> "You know, the category B design, yes, comes with a couple of concrete yards, and there's- you know, there's not enough space. Brook House is right next to the runway at Gatwick, so it's extremely noisy, you hear the planes landing and taking off all the time. It's a very, very harsh environment to be in."[38] (emphasis added)

45. Mr Petherick explained that whilst Brook House was built to Category B standards:

> "But not as a category B prison, because a cat B prison would have far wider ranges of sporting activities, educational activities, et cetera…
> [Brook House] was designed as a short-term holding centre. As it developed, detainees were held there for longer, and that's really when the frailties of the design became apparent, with the lack of outdoor space, with sporting space, with sports halls, education. We did what we could to alleviate some of those issues. But the fact remained that the site was incredibly cramped and so, as the length of detention increased, ad as other factors came into play- I've got no doubt we will talk at some stage about foreign national offenders, and so forth- and that, again, increased the challenges."[39]

46. Mr Bhui, the Inspection Team Leader at Her Majesty's Chief Inspector of Prisons, told the Inquiry, that Brook House:

> "…looks and feels like a prison, and it is designed like a prison. As we have said many times, that's inappropriate for a detainee population.[40]
> ….
> I think there is only so much which can be done with the design of centres like Brook House. You know, they're very limited. There isn't enough

[36] INQ000064_0043, paras 9.8-9.9

[37] INQ000064_0043

[38] Professor Bosworth, 29 March 2022, 33/11-16

[39] Mr Petherick, 21 March 2022, 55/6-56/3

[40] Mr Bhui, 24 March 2022, 154/3-7

> space. Any they don't look and feel the way that immigration detention should do, in my view."[41]

47. Of course, G4S had no control over the design of Brook House. Whilst it has sought to mitigate and soften its oppressive nature there was only so much that could be done. Mr Bhui acknowledged this:

> "Well I think Brook House management have tried to mitigate the problems of having a centre which wasn't really designed to have long-term detainees in it. So by providing more activities, trying to provide more work. But it can only every really take the edge off the experience, I think if you do that.[42]

48. This *"very, very harsh environment"* inevitably has an adverse impact on both detainees and staff. It made *"delivery of a humane and supportive regime very difficult"*.

Framework within which G4S operated

49. 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 their treatment within Brook House.[43] Recalling that detained persons were held at Brook House prior to 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. The Her Majesty's Inspectorate of Prison's report published in January 2017 recorded that, *"the average length of detention at Brook House had increased substantially from 28 days to 48 days"*.[44] This length of detention increased further during the Relevant Period.

50. 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

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[41] Mr Bhui, 24 March 2022, 155/19-23

[42] Mr Bhui, 24 March 2022, 178/21-179/1

[43] Eg HMIP Brook House IRC Inspection, January 2017, CJS000761_0005

[44] HMIP Brook House IRC Inspection, January 2017, CJS000761_0005

not responsible for escorting detained persons as part of removal directions; and it 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' queries and frustrations, often simply unable to assist and in an understandable position of ignorance.

51. In that regard, the physical architecture of Brook House again plays an important role: time-served foreign national offenders were transferred from a prison to an environment which looked remarkably similar to the prison from which they had come, 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 staff, but abused them – verbally and physically.

The Procurement and the Contract

52. In the context of an operation which had been outsourced by central Government, the contractual arrangements between G4S and the Home Office (and, where relevant, the health contract) are fundamental to understanding how Brook House was operated before, during and after the Relevant Period. Even through 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). It is important to remember that G4S did not agree or negotiate the terms of the contract that was in force during the Relevant Period, but rather took over the contract that had been agreed between the Home Office and GSL.

53. The terms of the contract were set by the procurement exercise designed by the Home Office. A number of witnesses including Mr Riley explained that at the relevant time the initial contract was procured, the focus was very much on minimising the costs to Central

Government.[45] This is quite clear from the Government's decision to have 50% of the bid scoring based on the cost of the contract to the Home Office.[46] Such an approach to the procurement inevitably led the various bidders to cut costs to the bone in an attempt to be awarded the contract, in line with what was essentially being asked 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 that the winning bid from GSL which was the lowest yearly price was 35% below the relevant budget.[47]

54. Such an approach can be contrasted with that taken in relation to the 2019 contract award where only 35% of the bid scoring was based on cost.[48] This different approach to the procurement process inevitably led to very different bids with far 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 was nonetheless bound by the terms of the contract with the Home Office based upon GSL's bid after it purchased GSL.[49] As a matter of both European and domestic procurement law, the terms of the G4S bid became irrelevant once the Home Office accepted the GSL bid.[50] This remained the case as a matter of law when G4S subsequently took over GSL. The procurement law regime also prevented G4S from seeking to substantially renegotiate the terms of the contract with the Home Office once it was signed by GSL.

55. The Contract as procured by the Home Office is clearly very important context to what happened subsequently at Brook House during the Relevant Period as it defined what was expected from G4S in relation to, inter alia, staffing levels and, by virtue of the penalty regime set the priorities that G4S needed to focus upon.

Challenges during the Relevant Period

56. An already challenging environment, became considerably more challenging during the Relevant Period for a number of reasons. As Mr Hanford explained in his oral evidence to the Inquiry, as a result of government austerity shortly before the Relevant Period, prisons

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[45] Mr Riley, 4 April 2022, 35/14-15. See also Mr Petherick, 21 March 2022, 22/23-23/13

[46] Mr Riley, 4 April 2022, 35/14-16

[47] Brook House Operating Contract Commercial Evaluation, DL0000140_0047

[48] Mr Riley, 4 April 2022, 35/17-18

[49] Mr Riley, 4 April 2022, 38/22-25

[50] Mr Riley, 4 April 2022, 41/12-19

were closing and the prison estate was no longer able to accommodate a large number of time served foreign national prisoners.[51] The proportion of such time served foreign national prisoners at Brook House increased from approximately 5% in 2013 to between 50-55% in 2017.[52] This coincided with a spice epidemic which had started in the prison estate and then migrated to the IRCs, in part, as a result of the transfer to IRCs of such prisoners from the prison estate.[53] Further, the introduction of "no-notice charters" in 2017 created further significant challenges. Mr Hanford was so concerned about the adverse impact this was having that he raised concerns at IMB meetings in late 2017.[54] The introduction of such charters was *"so detrimental to the relationships within the centre"*[55] because they undermined trust between detainees and staff who were required to be evasive and disingenuous about when flights were to take place.[56]

57. Such changes 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 mistreatment of detainees 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.

Comparison with Tinsley House

58. Tinsley House, like Brook House was run by G4S. However, the almost unanimous evidence was that Tinsley House was very different to Brook House. For example, Mr Syred, in his oral evidence, explained the different between the two establishments in the following way:

> "Tinsley was a much calmer environment. The staff seemed to work better together, and a lot of the staff at Tinsley had been there a long time, and they did work together. There was a lot less violence, a lot less threats, and it was, and it was a very much more- it was actually designed as a hotel for air cabin crew, originally. So it didn't have that feeling of being like a prison."[57]

[51] Mr Hanford, 15 March 2022, 77/2-78/9

[52] Mr Hanford, 15 March 2022, 78/9-13

[53] Mr Hanford, 15 March 2022, 78/14-18

[54] Mr Hanford, 15 March 2022, 84

[55] Mr Hanford, 15 March 2022, 85/1-3

[56] Mr Hanford, 15 March 2022, 86/5-87/10

[57] Mr Syred, 7 December 2021, 23/18-24.

59. Brook House and Tinsley House were both within the same management team falling within Mr Petherick's domain and ultimately, Mr Neden. Whilst the senior management team were the same in these two establishments, the key differences between these two establishments were the physical environment and the detainee cohort. This suggests that a significant cause of the misconduct was the physical environment and the nature of the detainee cohort rather than any failures by senior G4S management.

Comparison with other Immigration Removal Centres

60. Mr Bhui in his second witness statement details an email he sent in September 2017 that Harmondsworth IRC *"may be worse than Brook House in many ways".*[58] Harmondsworth IRC was, at the time, run by the Mitie Group. The basis for this comment was expanded upon in his witness evidence:

> "[the basis for the comment was] the findings of the previous inspection of Harmondsworth, the intelligence we had received and the fact that I had just heard about a self-inflicted death there. The healthy establishment scores at Harmondsworth in 2015 in relation to safety, respect and activities were all "not sufficiently good" and a wide range of concerns were highlighted."[59]

61. Of course, the fact that Brook House was, perhaps, better than certain other Immigration Removal Centres does not justify the mistreatment of detainees however, it provides important context relating to the inherent challenges of running Immigration Removal Centres, particularly the larger IRCs built to replicate prison levels of security.

Custodial matters

Recruitment

62. G4S submits that the approach to recruitment could not have any meaningful causative impact on any misconduct associated with mistreatment of detained persons. It accepts that recruitment is linked to the issue of staff numbers, but beyond that there was nothing about how recruitment processes were carried out that could have, itself, caused or contributed to the mistreatment of detained persons.

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[58] Mr Bhui, HMIP000697_0003, para 11. The email is at HMIP000130.

[59] Mr Bhui HMIP000697_0003, para 11.

63. The Inquiry should take a pragmatic approach when considering matters of recruitment: firstly, appreciating that there is an inevitable time lag between the need for new recruits arising and when those recruits undertake their first shift – not least because of the need for those new joiners to undertake the ITC and obtain Home Office accreditation, as well as advertising and running recruitment days. These processes understandably take time.

One criticism of the recruitment process that has emerged during the course of the Inquiry's hearings is that it did not prepare staff for the reality of life in an IRC. In Chris Donnelly's evidence, for example, he said: "*It didn't make clear the sort of environment that we would be going into. There was nothing specifically about we were going to be dealing with so many foreign national prisoners, ex-foreign national prisoners. There was nothing like that in the recruitment*". When asked what part of the recruitment process he was speaking about, he said "*the initial job advertisement*".[60]

64. Again, G4S invites the Inquiry to take a realistic approach to this issue. On the one hand, it could be suggested that as clear a picture of life inside an IRC should be used in recruitment campaigns. Doing so would minimise the risk of new joiners being under any illusions about the difficulties of life as a DCO, and thus reduce the frequency of cases where staff left shortly after joining, on the basis that they did not realise what the job entailed. On the other hand, life in an IRC – as a DCO – is not easy. The Inquiry has seen what the reality is like, entailing as it did on many occasions, abusive from detained persons and the need, where necessary to put one's self at risk in use of force incidents. Putting aside for one moment the difficult in conveying those messages in a newspaper advertisement, at times where the Company struggled to recruit new DCOs, painting a picture of a role in a stark and difficult environment would only have made that process of recruitment more difficult.

65. The criticism that staff did not consider themselves prepared for what was to come on the wings is better aimed, it is submitted, at the training process more than the recruitment process.[61] In respect of the former, it can be addressed through more shadowing – a part of the process which was complimented by staff.[62]

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[60] Chris Donnelly 23 February 2022 57/13-22

[61] See Shayne Munroe 4 March 2022 3/25-4/2

[62] Nathan Ring 25 February 2022 7/15-18

66. G4S invites the Inquiry to take note of the dose of reality given by Dan Haughton in his evidence:[63]

> "It's very difficult to recruit into, it always has been, to find the right people. So that's one thing. It's -- we have found recently, in the last few months, it's a very competitive labour market, so lots of people are -- where we had a surge of recruitment in during Covid, where people were displaced from their sort of professions, those people are now going back to their previous professions. And it's a tough place to work. It's not an everyday job, and I don't think it's something that, with all the training in the world, you can fully prepare people for. So I think some people get into it and realise that it's not for them. It's -- the officers do a very, very tough job" (emphasis added)

Training/induction

67. New DCO recruits to Brook House went through the 'ITC' – the initial training course, which lasted six weeks in total, including a period of time work-shadowing on the IRC floor.[64] Gordon Brockington sets out an overview of the induction and training process in his first witness statement.[65] The ITC is a detailed induction course and the evidence heard by the Inquiry was generally positive as to its contents and delivery. That is of course not to say it was perfect or without room for improvement. Indeed, as Gordon Brockington explains, a new ITC was already being piloted when G4S' contract to provide detention services at Brook House came to an end.[66] The ITC was professionally developed and delivered, with the majority of those delivering the training qualified to (or working towards) a Level 3 Award in Education & Training – a process approved by the Home Office.[67]

68. Moreover, in hearing from various witnesses who had gone through the training process, the Inquiry heard first-hand positive experiences. For example:

    (a) Shayne Munroe described the quality of the use of force training, in particular, as "*excellent*".[68] Indeed, the trainers "*ensured that the whole group was able to correctly*

[63] Dan Haughton 16 March 2022 154/13-25

[64] Nathan Ring 25 February 2022 3/23-/24

[65] CJS0074041_0012-0016, paras 48-70

[66] CJS0074041_0016, para 69

[67] CJS0074041_0015, para 62; see also Gordon Brockington 31 March 2022 8/5-21

[68] INN000013_0011, para 34

do what they had demonstrated before they moved on. If a trainee was struggling, they would work with them individually."[69]

(b) David Webb described the quality as good – his evidence is that "*the content was relevant, informative and explained well by trainers*".[70]

(c) Owen Syred said that the training was "*very good*".[71]

(d) John Connolly was asked whether he thought the ITC sufficiently prepared officers for what they were going to be confronted with. He confirmed that it was – and that it included 40 hours of C&R training.[72]

(e) The C&R element of the ITC was 'pass or fail' and if a recruit did not reach a suitable standard on any element, or displayed behaviour that was not conducive to G4S standards, they would fail the assessment and would not be permitted to have a detainee-facing role.[73]

69. There are, however, certain lessons to be learned. John Connolly reflectively accepted that "*looking back*", the training was "*too geared towards the prison estate rather than the detention estate*".[74] G4S can appreciate that observation and recognises the benefits in having C&R training tailored towards detention facilities. However, it should be recognised that the underlying standards governing the use of force were ultimately derived from prison-focused manuals, guidance and policies – chief of which was PSO 1600, a prison service order. In those circumstances, where officers were ultimately subject to underlying standards which were prison-focused or prison-derived, it is understandable that they were ultimately trained to those standards. If the Inquiry is minded to make recommendations in respect of the nature and focus of C&R training, G4S submits that it cannot do so in isolation, or in ignorance of the facts that the underlying standards (which are not set by G4S) are prison-focused. The two go hand-in-hand.

70. Beyond the question of C&R training, it is worth addressing specifically the question of how DCOs were trained in relation to mental health. This is, as demonstrated by the course of

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[69] INN000013_0011, para 34

[70] INQ000114_0004, para 24

[71] Owen Syred 7 December 2021 6/24

[72] John Connolly 2 March 2022 136/23-24

[73] John Connolly 2 March 2022 138/5-13

[74] John Connolly 2 March 2022 138/17-139/6

the Inquiry's hearings, a difficult issue. That is because DCOs are not medically-trained personnel; nor is there a realistic expectation that they should have the same experience and training in matters of mental health as healthcare staff. Mental health matters are a specialism that calls for healthcare expertise. On the hand, there are certain types of behaviours that detained persons may display that could be relevant to the use of force against them: some of those behaviours may be similar when displayed by a detained person exhibiting them because of a mental health condition; as when they are displayed by a disruptive or refractory detained person. DCOs, as non-medical experts, are sometimes inevitably in the invidious position of having to deal with a detained person displaying such behaviour, without the tools to identify whether the root cause is a mental health condition or an intention to disrupt. It may be necessary for force to be used in any event (e.g. if the detained person is at risk of harm), but an understanding of whether there are mental health issues at play may have a bearing on the nature of force used and the approach taken by staff.

71. In his evidence, Lee Hanford explained that on the ITC the "*training for staff relating to mental health was a bit of a -- it was a segue, really, into ACDT management, et cetera.*"[75] His evidence was insightful in explaining the process by which third-party providers were brought in to assist on this front. Indeed, in recognition of the fact that custodial officers are not – and should not – expected to be mental health experts, the appropriate approach was instead to give them the tools to be aware of the signs of mental health conditions, so that appropriate expertise could be sought: "*we weren't training people into mental health workers, it was just an awareness of mental health concerns*".[76] When the Inquiry considers this aspect of training of custodial staff, G4S respectfully suggests that this be the appropriate guiding principle.

72. Dan Haughton described his role in delivering the mental health training as part of the ITC. His evidence echoes that balance between recognising that custodial staff are not mental health practitioners, but do need the tools to be able at least to identify mental health concerns:[77]

> "I think it was about a four-hour session in the morning. It was part of the Prison Service package around self-harm and suicide prevention, so it was called an introduction to mental health. And that was the sort of established standard that people needed to complete. Again, I've heard mental health training discussed a lot in the inquiry, and, again, it's a difficult one to

[75] Lee Hanford 15 March 2022 125/10-13

[76] Lee Hanford 15 March 2022 126/11-13

[77] Daniel Haughton 16 March 2022 149/18-150-8

> quantify what the right amount is. Because we are not training people to be clinical staff, we are not training them to diagnose. What we want our officers to be able to do is identify a concern with a resident and say, "I'm not happy with that" and refer them to the professionals for them to have a full and proper assessment with a medical professional."

73. As Mr Haugton explained, post-Panorama he and Lee Hanford carried out a lot of work in this area and brought in additional mental health first aid training for staff. It lasted a day and was affiliated with Mental Health First Aid England. He described this as "*beneficial as it allowed us to better identify issues and spot concerning behaviour*".[78] This new training was not only delivered to new joiners as part of the ITC from 2018, but Dan Haughton explained that "*existing staff would attend the ITC to also get it. So we were upskilling not only the new staff, but the existing staff, and we tried to prioritise the sort of E wing and CSU staff because that's obviously where it is*".[79]

74. The provision of mental health training is an area that is clearly under constant review and improvement, as wider standards develop beyond the IRC estate. Indeed, while improvements have no doubt been made since Panorama, and there will be scope for further developments in light of the Inquiry's recommendations, it is important to recall Owen Syred's evidence that the position by 2014 was a marked improvement on what had come before. He observed the improvements in relation to: "*The awareness. The training. The awareness. The importance. You know, this document is someone's life and this is how we -- this is how we, as officers, care for someone who is in crisis.*"[80] He was asked specifically about the position in around 2017 in relation to ACDTs:[81]

> "…it was much improved from when I first started working there. So around about 2017, it had been highlighted more as a very important part of what a DCO does, or a DCM. So -- and it was incorporated more in the training, and so, yeah, officers were aware that, if you get this wrong, you know, you could end up in a coroner's court. So it seemed in everyone's interest. We didn't want a death in custody, and it was -- personally, to me, that was important."

Staffing levels

[78] SER000453_0007, para 23

[79] Daniel Haughton 16 March 2022 151/1-5

[80] Owen Syred 7 December 2021 78/24-79/2

[81] Owen Syred 7 December 2021 79/23-80/7

75. G4S accept that a number of junior staff suggested that staffing levels were too low on the wings at Brook House. Both Mr Brockington[82] and Mr Neden[83] accepted that staffing was difficult during the Relevant Period although that was the case across the "*whole custodial and detention industry*".[84] However, it is important to bear in mind that there is a difference between DCOs' perception as to the level of staffing on the one hand and whether G4S failed to provide the required level of staffing under the contract on the other. As Mr Castle, of the Home Office, explained, G4S's job was to deliver the staffing required by the contract:[85] if the staffing in the contract was insufficient, responsibility for that lay with the Home Office. Mr Brockington set out the staffing levels in his witness statement.[86] There were shortfalls during this period due to staff vacancies: staffing levels were 100% in April and May, 90% in June, 81% in July and 87% in August.[87] For the majority of the time staffing levels were in accordance with what was required under the contract with the Home Office. Overtime was used to cover the majority of the gaps in staffing.[88] The limited shortfalls led to a penalty of £2,250 over the three months indicating that the Home Office (through their contract) did not regard the shortfall as particularly serious.

76. As detailed above, recruitment was a challenge at Brook House given its proximity to Gatwick Airport and the many employment opportunities available there. Further, given the challenging environment at Brook House, there was inevitably a degree of staff attrition[89] although G4S took a number of steps to retain staff including bonus payments for, inter alia, absence free periods of employment and length of service payments.[90]

77. CTI suggested to Mr Saunders that G4S kept vacancies at Brook House open to avoid costs and increase profits. However, Mr Saunders made clear that this was not the case.[91] Further, as Mr Neden explained vacancies needed to be covered by overtime which is not "*the ideal*

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[82] Mr Brockington ws, CJS0074041_0009, para 36.

[83] Mr Neden, 22 March 2022, 37/18-20, 38/3-5.

[84] Mr Petherick, 21 March 2022, 45/3-5.

[85] Mr Castle, 15 March 2022, 10/6-21.

[86] Mr Brockington ws, CJS0074041_0008, para 31.

[87] CJS000524

[88] Mr Brockington ws, CJS0074041_0008, para 31.

[89] Mr Saunders, 22 March 2022, 167/6-7.

[90] Mr Saunders 1st ws, KEN000001_0019-0020, paras 100-107.

[91] Mr Saunders, 22 March 2022, 166/14-16, 168/9-10.

way to manage shifts".[92] Mr Petherick explained that covering vacancies using overtime would impose "*additional costs*".[93]

78. When G4S's contract was extended in 2017, the Home Office agreed, inter alia, to increase staffing levels from 2 DCOs per wing to 3 DCOs per wing.[94] Such an increase amounted to a recognition that the staffing levels set in the 2009 contract originally entered into between the Home Office and GSL were inadequate. This was broadly accepted by Mr Gasson who said:

> "The minimum staffing levels [in the 2009 contract] were probably set at a time when perhaps the focus wasn't so much on welfare as it is now. I think, on reflection, if it was done again, and it has been done again recently, you can see the increase in staffing…"[95]

79. The 2009 contract did not dictate the number of members of the senior management team at Brook House; that was a matter for G4S. In March 2016, Mr Hanford expanded the SMT when he introduced the role of head of safeguarding and a head of support services, the latter which was filed by Mr Haughton.[96]

80. G4S do not accept that the staffing levels during the Relevant Period caused or contributed to the mistreatment of detainees: Twenty three of the 53 incidents of concern took place during April or May when staffing levels were at a 100%. The rate of incidents during the Relevant Period was thus lower during the months where staffing levels were lower rather than higher. The evidence thus supports G4S's position. However, to the extent that the Inquiry reject G4S's case on this, it should conclude that it is the Home Office's decision to set the staffing levels in the 2009 contract at too low a figure rather than any failure by G4S to recruit a full cohort of staff in a challenging employment market that caused or contributed to such mistreatment.

Staff Culture: senior staff

81. Mr Petherick explained in his oral evidence explained that there were particular challenges as the SMT level at Brook House because, when the previous head of G4S Immigration

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[92] Mr Neden, 22 March 2022, 38/19-22.

[93] Mr Petherick, 21 March 2022, 47/19-23.

[94] Mr Brockington ws, CJS0074041_0009, para 37, quoting the IMB 2018 Annual Report.

[95] Mr Gasson, 15 March 2022 173/11-15

[96] Mr Hanford, 15 March 2022, 66/22-67/18.

Services (Mr Andy Clarke) left G4S to join a competitor, he took with him "*the top three layers of management from Brook House*".[97] This departure caused significant problems. Unfortunately, a grievance culture developed at Brook House prior to the Relevant Period. Mr Petherick[98] and Mr Hanford[99] in their oral evidence detail the extensive steps that they both took to improve the culture and, given the subsequent reduction in grievances made against senior staff by other senior staff it is clear that such efforts were broadly successful. However, G4S accept that the grievance culture within the SMT was broadly unhelpful and did impact, to a degree, on management of Brook House prior to the Relevant Period although it did not cause or contribute to the mistreatment of detainees.

Staff Culture: junior staff

82. If the Inquiry bases its views on staff culture amongst junior staff on the selective footage gathered by Mr Tulley and the evidence from a small minority of staff who mistreated detainees, it will no doubt conclude that there was a fundamental problem with the junior staff culture. However, as detailed above, Mr Tulley's footage showing a small number of staff filmed mistreating detainees is wholly unrepresentative of the vast majority of G4S staff at Brook House during the Relevant Period. Ms Syred accurately summarised the position as follows:

> "The Inquiry has seen and heard about the worse of Brook House but there is also another side which was not shown in Panorama or drawn out in the inquiry hearings. It 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. …."[100] (emphasis added)

83. Mr Syred's analysis accords with the IMB annual report of April 2017 which stated:

> "Once again the IMB judges Brook House IRC to be a well-run establishment, providing a decent environment where detainees awaiting removal are treated humanely and fairly. Management, under the direction of Ben Saunders, has high expectations of staff and there are many examples of good and dedicated work by officers and managers and a continuing commitment to safety. The Board remains pleasantly surprised

[97] Mr Petherick, 21 March 2022 136/21-24.

[98] Mr Petherick, 21 March 2022 136/13-138/12.

[99] Mr Hanford, 15 March 2022, 67/19-75/4

[100] Closing Statements, 5 April 2022, 170/9-181/1.

> how open management is to suggestion and constructive criticism. There is a real will among the management team to seek to improve and a "can-do" culture of transparency. This attitude permeates to the officers in their attitude to the IMB, which is one of cooperation and helpfulness."[101]

84. Such an assessment of the broad staff culture at Brook House accords broadly with the HMIPP January 2017 report which refers to *"the standards now being observed at the centre are the result of a great deal of hard work by management and staff. They should be congratulated on their efforts and I hope are encouraged by this report to maintain and build upon the clear improvements they have made."*[102]

85. G4S accept that staff morale was not as high as it had been mainly as a result of the particularly challenging circumstances caused by matters beyond G4S's control that profoundly impacted on Brook House during the Relevant Period.[103] However, Mr Skitt's view that the majority of staff showed a "*professional and caring attitude towards residents in the environment within [Brook House]*"[104] is accurate.

86. Specific aspects of staff culture such as the use of inappropriate language are dealt with elsewhere in these closing submissions. However, it is clear that such culture did not contribute to or cause the mistreatment of detainees by a small minority of staff during the Relevant Period.

Inappropriate, racist and sexist language

87. Mr Collier also observed the recording of "*inappropriate and racist comments made in the perceived safety of offices*", some of which appeared to go unchallenged by other staff members.[105]

88. The footage filmed undercover by Callum Tulley does disclose a number of incidences where staff members used language that was coarse and unprofessional (e.g. use of swear words) and, in a small minority of instances, racist. It should be clear to the Inquiry, however, that when the use of such language came to the notice of mangers, it was cracked down upon with disciplinary action. In his oral evidence, Jerry Petherick explained (by

[101] IMB000131_007, para 4.1.

[102] CJS000761_0005

[103] See paragraphs 56-59 above.

[104] Mr Skitt's 1st ws, SER000455_0013.

[105] INQ000111_0014, para 30

reference to a question regarding what he would have done if he heard an officer refer to a detained person as, for example, a 'dickhead'):[106]

> "I would have addressed it immediately. I would have followed it up and, in all probability, by disciplinary action, because that is totally unacceptable to every bit of my being and other people's beings, and if I walked by it and didn't address it, then I would be condoning it. And so I can remember many occasions during my career when I have had very direct conversations with staff who have used inappropriate language or who have failed to address it. Sadly, I can only directly deal with what I hear, and you will know, and I will know, that most people will be aware if I was walking around and so forth, be it as a governor, an area manager, an MD. I would certainly address those issues directly and forcefully."

89. G4S addresses the use of inappropriate language in its submissions below on the 53 incidents investigated by the Inquiry – primarily by reference to the particular instances when the issues arises. What those examples demonstrate is G4S' zero tolerance attitude to such unprofessional language. It does recognise that staff using foul language in the confines of a staff room is not the same as doing so in front of a detained person, particularly where the language is about or direct at a detained person. That is relevant at least to the Article 3 analysis – where such conduct is likely to be more humiliating where the comments are made to a detained person directly. To be clear, however, such use of language - both about detained persons and generally – are not acceptable, and fall below the standards expected by G4S of its staff. As the example of Nathan Ring shows (see Row 35 of the Schedule of Incidents), while these comments may have been the exception rather than the rule, G4S considered them wholly unacceptable. Notwithstanding that Nathan Ring had already tendered his resignation and had been suspended on a precautionary basis, following his disciplinary hearing he was summarily dismissed. More than that, the examples of Babs Fagbo and Shayne Munroe (see Row 8 of the Schedule of Incidents) make plain that taking a hard line of inappropriate language was not a knee-jerk reaction to the airing of Panorama, and was G4S' consistent approach, even where disciplinary action was taken before Panorama.

90. Ultimately, while the undercover footage discloses a number of examples of the use of swear words between officers – often in private (as well as used by detained persons), it also shows there to be very few instances where coarse or inappropriate language was used by officers

[106] Mr Petherick 21 March 2022 37/12-25

about or to detained persons. It certainly was not the norm; nor did the use of such language cause of contribute to any mistreatment within the scope of Article 3 ECHR.

Drugs

91. G4S accept that during the Relevant Period there was a significant drugs problem within Brook House with spice. However, Brook House was not unique at this time: spice was a very significant problem throughout the prison estate and other Immigration Removal Centres.[107] Mr Neden's evidence that the level of illegal drug use at Brook House during the relevant time was *"much lower in Brook House compared with the prison estate"*[108] was rightly not challenged. Mr Skitt, in the context of describing a high level of medical first responses over a 24 hour period as a result of spice use said:

> "This was not because of security lapse, it (ie drugs) was just something that took hold of both this immigration centre, every prison in the country and the community at the time. We worked tirelessly to try and stop the ingress of these drugs into the centre…"[109]

92. The idea that it was possible to keep spice out of Brook House when more secure prison environments had, during the Relevant Period (and to a great extend still do) severe problems with spice use is unrealistic.

93. Mr Brockington's witness statement explained the extensive steps that G4S took to prevent drugs from entering into Brook House:

(a) all visitors and property were searched before granting access;

(b) regularly searches of bedrooms, communal areas and the external grounds were carried out;

(c) staff were subject to random searches including staff lockers and personal belongings. However, no drugs were found during these searches;[110]

(d) staff were also given anti-bribery and corruption training.[111]

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[107] Mr Petherick, 21 March 2022, 66/7-19.

[108] Mr Neden, 1st ws, INQ000119_0018, para 77.

[109] Mr Skitt 1st ws, SER000455_0012, para 42.

[110] Mr Skitt 1st ws, SER000455_0043, para 139

[111] Mr Brockington's 1st ws, CJS0074041_0031, para 148

94. Mr Syred confirms that such searches took place. He stated:

> "In respect of the steps taken to prevent drugs entering Brook House, anyone attending the centre would be subject to a search, including legal teams, and charities. G4S staff were subject to random searches, and I was personally subject to a number of searches. Contractor attending the centre needed to have an inventory for their tools and equipment."[112] (emphasis added)

95. G4S requested that UK Border Agency drugs dogs be used at the centre to perform drugs searches.[113] Unfortunately, the dogs only attended on a couple of occasions due to competing demands on the UK Border Agency.[114] My Syred complains that staff were not subject to random drugs tests.[115] However, there is no basis for suggesting that such testing, which is difficult from an employment law perspective, would have meaningfully assisted keep drugs out of Brook House.

96. G4S also has an extensive security operation which monitors local intelligence using the SIR process. Suspicions of staff or detainee involvement with drug importation was documented through this process. However, it was not possible to take steps immediately that suspicions were raised about a particular member of staff. Such intelligence needed to be considered and the matter monitored and investigated. As Mr Brockington noted, *"More often that not, when staff members became suspicious about their monitoring, they would resign before any/sufficient evidence could be obtained to refer the matter to the police to commence formal disciplinary proceedings."*[116]

97. It is notable that the HMIPP did not raise the use of drugs as one of its "Main Concerns and Recommendations" in in January 2017 report.[117] This reflects the fact that G4S and its staff where take all reasonable steps to reduce illegal drugs use but, like the rest of the custodial estate and other Immigration Removal Centres, were faced with an impossible task of keeping drugs (particularly spice). In light of the above, there is no basis for concluding that G4S's response to the spice epidemic (or illegal drugs more generally) contributed to, or caused the mistreatment of detainees at Brook House.

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[112] Mr Syred 1st ws, INN000007_0017, para 73.

[113] Mr Skitt 1st ws, SER000455_0043, para 138.

[114] Mr Skitt 1st ws, SER000455_0043, para 138.

[115] Mr Syred 1st ws, INN000007_0019, para 82.

[116] Mr Brockington's 1st ws, CJS0074041_0031, para 150

[117] Mr Neden, 1st ws, INQ000119_0018, para 77.

Language barriers and use of interpreters

98. Like the issue of co-location of TSFNOs with asylum seekers, language barriers and use of interpreters was included in the list of topics that the Inquiry intended to examine but hardly featured in questions to G4S witnesses. In particular, no questions were asked about use of interpreters to the corporate witnesses (Mr Dove and Mr Brockington) or other senior G4S management in place at the time including Mr Neden, Mr Petherick and Mr Hanford. Whilst Ms Williams noted that obtaining an appropriate interpreter for a detainee attending a healthcare appointment may occasionally be difficult, Ms Williams did not suggest that it was a consistent problem during the Relevant Period.[118]

99. Further evidence as to the lack of difficulties with language barriers and use of interpreters can be gained from the 2017 report on Brook House from Her Majesty's Chief Inspector of Prisons which stated:

> "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. We saw staff dealing with a range of issues with resilience and even-handedness. Many staff integrated will with detainees…"[119]

100. If language barriers and use of interpreters were a problem during the Relevant Period, one could expect dissatisfaction with detention to be higher with detainees who did not speak English however, in fact the precise opposite was the case. In such circumstances, there is no basis upon which the Inquiry can conclude that language barriers or problems with the use of interpreters caused or contributed to any mistreatment of detainees.

Co-location of Time Served Foreign National Offenders with asylum seekers

101. Whilst the issue of co-location of Time Served Foreign National Offenders (TSFNO") and asylum seekers was included in the list of topics that the Inquiry intended to examine, it hardly featured in the oral evidence heard by the Inquiry. In particular, no questions were put to G4S's corporate witness, Mr Brockington on this issue. Whilst Mr Hanford discussed the additional challenges that arose during the Relevant Period as a result of the increase in

[118] Ms Williams, 10 March 2022, 93/16-94/12.

[119] CJS000761_0015, para S16.

the number of TSFNOs as a result this is, of course, a different issue.[120] In such circumstances, there is no basis upon which the Inquiry can conclude that such co-location caused or contributed to any mistreatment of detainees.

Use of force/Control and Restraint

102. Within the context of an IRC there are occasions on which force is required to be used on detained persons by staff. That is recognised by Rule 41 of the Detention Centre Rules 2001, which prohibits "*unnecessary*' use of force and requires that all force used be no more than is necessary. Moreover, Rule 41(2) prohibits officers acting in a manner calculated to provoke a detained person; and Rule 41(3) provide for the recording of uses of force and the reporting of these incidents to the Secretary of State.

103. G4S makes submissions on the individual 'incidents' under investigation by the Inquiry below, many of which are incidences of the use of force being used (or alleged to have been used). It is appropriate, however, to address some of the broader themes that have emerged from the evidence, in particular the observations made by the Inquiry's use of force expert, Jonathan Collier.

104. As mentioned above, while the Inquiry's focus is (understandably) on areas or instances of concern, it should not be forgotten that the evidence suggests that the vast majority of staff and occasions demonstrated good, professional practice. That was the everyday life at Brook House; not the particular snapshots shown on Panorama. Indeed, Mr Collier's overall findings were:[121]

> "21. There are many examples of good engagement by staff, notably the DCM group, when trying to resolve difficult situations, especially removal for transfer from the centre. The tone and demeanour is mostly non-threatening and non-aggressive, but conducted with the correct level of authority. A good example is incident 164/17 managed by DCM Robinson, where he demonstrates a calm assertive figure during a particularly difficult situation.
>
> 22. Good de-escalation after the initial restraint and early removal of restraints once they are no longer required. An example being when releasing the head support position to allow the detainee to stand upright, which occurred during most interventions."

[120] See paragraphs 56-59.

[121] INQ000111_0012

105. However, Mr Collier did also highlight some particular areas of concern from his review of 43 incidents. Subject to some particularly aspects explained below, G4S broadly accepts these and recognises that these constitute important areas in respect of which lessons can be learned, and which may form the basis of recommendations that the Chair may be minded to make. These are points of constructive criticism made by Mr Collier, although it is submitted that while these 'learning points' are apposite, and which could improve practice going forwards, their non-implementation during the Relevant Period was not causative of any particular inappropriate use of force, let alone any mistreatment of detained persons.

106. Mr Collier identified "*the failure to activate all available BWVC during incidents, and when responding to a general alarm*" as a particular area of concern.[122] However, it is right to point out that the applicable Use of Force policy during the Relevant Period (effective from March 2016) provided that: "*all 'planned use of force' will be recorded using a hand held video camera; this may include the use of a Body Worn Camera worn by the Use of Force Supervisor*".[123] That echoes Gordon Brockington's evidence that BWVC's were formally introduced in place of hand-held cameras post-Panorama (i.e. after the Relevant Period).[124] It also echoes evidence heard by the Inquiry from a variety of officers and managers, who, when asked why that had not activated a BWVC during a particular incident gave an explanation to the effect that these were relatively new and so they were not sufficiently practised with the BWVC to 'automatically' activate it during any use of force incident.[125] Mr Collier picked up this point, himself, in his own evidence that:[126]

> "Where the real failure and where the omission was at Brook House at the time was that sort of culture where people when they responded to automatically activate their body cameras so that they could get a wider picture of what was going on."

107. G4S can see the clear benefit in a practice of officers activating BWVC as soon as incident is triggered; which is precisely why it was formally incorporated as a matter of policy in December 2017. It would endorse this aspect forming part of the Chair's recommendations for future practice; however respectfully suggests that some of Mr Collier's specific criticisms in this regard are not wholly warranted, where BWVC had yet to formally become

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[122] INQ000111_0012

[123] CJS000360_0007

[124] CJS0074041_0036, para 178; referring to the policy at CJS0073866

[125] See, e.g., Chris Donnelly 23 February 2022 143/19-2144-8; Shane Farrell 8 March 2022 109/6-9

[126] Jonathan Collier 30 March 2022 157/13-17

part of policy until after Panorama (but were in the process of introduction as can be seen in relation to certain of the incidents). Furthermore, some understanding should be given to officers during the Relevant Period which was, in essence, a 'bedding in' period for the use of BWVC. It understandably takes some time for it to become second nature to staff to activate the BWVC; especially when force is required spontaneously, and staff have to prioritise safety, of the relevant detained person, themselves, and other individuals in the vicinity; as well as trying to coordinate action. That was a point made in oral evidence by Steve Dix: that during spontaneous incidents, in particular, it is difficult always to recall to activate the BWVC right away.[127]

108. Mr Collier also suggest that there was a "*lack of understanding between a planned and unplanned incident*" in that "*some incidents observed were actually planned, in that sufficient staff were in attendance and there was no immediate requirement to use force*".[128] G4S understands and accepts that point, but would perhaps reword it slightly. It is not the nature of the staff present that dictates whether an incident is deemed to be 'planned' or not. Rather, the real point here is that some uses of force were unplanned, but perhaps could have been done on a planned basis. An incident may have arisen which ultimately would require force to be used to – for example – transfer an unwilling detained person to the CSU. With minimal staff initially present, it may have nevertheless have been necessary to carry out an unplanned use of force to – for example – remove a ligature or take some other action for the safety of the detained person. However, if that detained person were unwilling to walk compliantly to the CSU, which was necessary, but did not need to occur immediately (because the imminent danger had been removed through the initial use of force), staff could in that case pause, cease any use of force, plan a further use of force (if necessary) to transfer the detained person to the CSU. Force would likely still be used but rather than 'continuing' the initial unplanned use of force all the way through the CSU transfer, the incident could be 'broken up' into an initial unplanned use of force to make the detained person safe, followed by a further, planned use of force to carry out the CSU transfer.

109. This appears to be the nub of Mr Collier's point in this regard, and there are some clear advantages to it. Planned uses of force are 'planned' for good reason: they ensure that the incident is video-recorded; that sufficient staff are present; that those staff have coordinated a plan of action for what is to take place; and healthcare are present, too. However, the

[127] Steve Dix 9 March 2022 64/20-21

[128] INQ000111_0012, para 24

Inquiry should be cautious before taking too rigid approach to this issue and should, instead, be flexible to the exigencies of a dynamic situation with competing risks and demands. For example, there can be detrimental ramifications to staff 'pulling out' or pausing a use of force incident, to enable them to return subsequently to carry out that use of force on a 'planned basis'. A good example of this is the use of force against D687 on 13 May 2015, in relation to which Mr Collier makes the point that once staff took the view that the ligature was configured in such a manner that it would not do serious harm to D687, staff could have returned to deal with his transfer as a planned – rather than unplanned – use of force. However, Dan Haughton's evidence was that taking such an approach could have in fact prolonged the incident by 30-40 minutes.[129] Its consequences, therefore, in particular circumstances could potentially be to escalate rather than de-escalate an incident. The Inquiry should be mindful therefore, not to advocate an approach which ties the hands of trained staff and is overly rigid where some flexibility should remain to reflect the variety of operational circumstances that exist.

110. Mr Collier also observed that in some instances UoF documents were not fully completed, with sections left blank.[130] That is not acceptable and does not accord with G4S training or expectation of staff. However, while Mr Collier is right to make this observation where it applies, G4S submits that on the Inquiry's review of the complete set of UoF reports available to it, it should conclude that these forms were generally completed to a more than satisfactory standard. Indeed, for the most part, in respect of any use of force – whether planned or unplanned – the documentation available to the Inquiry demonstrate that accounts were provided by the officers involved. More than that, those accounts were not a matter of a few lines, but contained detailed description, incorporating both the narrative of what transpired, as well as explanations and justifications for action, where appropriate.

111. One slightly caveat to that which emerged during the Inquiry's oral hearings was the understanding (or possible misunderstanding) that it was only the officers who had 'hands on' during a use of force incident who were expected to complete a use of force report. Ryan Bromley, for example, gave evidence as follows:[131]

> "Q. Is it right to say that if somebody hasn't put hands on a detainee, they don't always fill in a use of force form?

[129] Daniel Haughton 16 March 2022 109/18-24

[130] INQ000111_0013, para 25

[131] Ryan Bromley 7 March 2022 102/5-10

> A. Back then, that was the policy. I believe now, if you are involved in the incident, you'd have to do at least an incident report."

112. The accurate position, however, according to the Use of Force policy in force at the time was that:[132]

> "All members of staff who were involved in using physical force will record exactly what their involvement was on the Annex A of the Use of Force report form.
>
> Any members of staff who witnessed the use of force incident will be instructed to complete an incident report; which will be submitted to the Use of Force Supervisor."

113. Accordingly, any staff member "*involved*" in the use of physical force would be required to complete a UoF report; whereas those who only "*witnessed*" the incident, would complete and Incident Report. Thus, even if there were any ambiguity as to whether someone who did not have 'hands on' during an incident, but may or may not have still somehow been 'involved', should have completed a UoF report, there is no doubt that such a person would have been required to complete an Incident Report. Any failure, therefore, by an officer present to complete a report – of some sort – in relation to a Use of Force incident would have constituted that individual's failure to follow protocol; not evidence of anything lacking in the protocol, itself.

114. In relation to Mr Collier's criticism concerning "*lack of senior management presence during incidents as set out in section 4.34-4.35 of PSO 1600*",[133] it is right to note two points: first, §4.35 of PSO 1600 states as follows: "*Planned C&R incidents are supervised by an officer who is accountable for the management of the incident until the prisoner is re-located ("the supervising officer"). Normally, this officer will be the Orderly Officer or Duty Governor*". Accordingly, when Mr Collier then goes on to state: "*I did observe the equivalent of the Orderly Officer attend, but seldom observed any senior management grade in attendance*", his observation that the equivalent of an Orderly Officer was in attendance in fact demonstrates compliance with §4.35 of the PSO. Moreover, the Use of Force policy in force during the Relevant Period required that any incident be supervised "*by a member of staff,*

[132] CJS000360_0010-0011

[133] INQ000111_0013

normally this will be the most senior member of staff present" (at the incident) – with no requirement that this be senior management.[134]

115. One area which G4S agrees is suitable for the Inquiry's recommendations based on the evidence it has heard is in relation to after-the-fact reviews of use of force incidents. Per the G4S policy in force at the time, there should have been a "Use of Force Committee" in place to monitor and review the use of force, meeting at least quarterly.[135] While there is some reference in the documentation to the existence of a use of force committee,[136] the position appears to be that summarised in the Verita report at §12.72 as: "*while use-of-force committee meetings had not happened, film and written records of use-of-force incidents had been reviewed by use-of -force instructors*". Whatever the position before, the committee was put on a formal footing post-Panorama.[137] It is not right, however, for the reviews that took place by use of force instructors during the Relevant Period to be described as a "*tick box exercise*".[138] Steve Webb, in his evidence, described his reviews as involving a form in which boxes were ticked; and was then asked by CTI whether it would thus be fair to describe it as a "*tick box exercise*". His answer was no: although the form did involve ticking boxes, it was not a 'tick box exercise' in the colloquial sense because "*you actually had to view the footage and make sure it was all correct*".[139] It was thus wrong and misleading for CTI subsequently to repeatedly describe Steve Webb's evidence as having described the review as a 'tick box exercise', when he had clearly stated it was no such thing.[140]

116. Mr Collier observes that there were often not "*clear negotiation strategies in place during planned removals*".[141] Indeed, one theme that emerges in his observations on various incidents concerns the extent to which staff should have undertaken further efforts to negotiate with a detained person who, for example, expressly stated their refusal to walk voluntarily to E wing or to a removal flight. Mr Collier, however, is right to observe in his

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[134] CJS000360_0007

[135] CJS000360_0014

[136] E.g., CJS0073064_0001

[137] CJS0074010_0002. See also Lee Hanford 15 March 2022 109/16-110/7

[138] See, e.g., INQ000111_0013, para 26

[139] Steve Webb 8 March 2022 177/6-8

[140] Paul Gasson 15 March 2022 197/15-19; Julian Williams 16 March 2022 8/22

[141] INQ000111_0013, para 28

general comments, as well as in relation to specific incidents that there may well have been previous conversations between the DCM and detained person at the time. On occasion those are referred to in the UoF documentation, but are not captured in the BWVC or handheld footage – because they occurred before the 'incident' formally commenced. In those cases, what had been said by a detained person shortly before a transfer was attempted would have been highly material to the DCM's view as to whether further efforts at de-escalation may have borne fruit and whether or not the 'last resort' had been reached. Negotiation is a key technique in seeking to avoid force as a 'last resort', as recognised in G4S' use of force policy in force during the Relevant Period.[142] Encouraging staff to think about potential negotiation strategies in advance of a potential use of force incident is therefore, in G4S' view, a sensible suggestion; and the Company agrees with Mr Collier that this could perhaps be facilitated through a more structured approach to pre-use of force briefings.

117. Mr Collier also points to instances of "*poor understanding and execution of techniques within the [use of force] training syllabus*".[143] In this regard, it is important to observe that Mr Collier's criticism is not with the syllabus, itself, or the techniques available to staff:[144]

> "I am satisfied that the practical system of restraints currently employed, when carried out appropriately, meets the requirement for instances when force is the last resort. The techniques have been medically evaluated and with the correct supervision, training and governance provide as safe a system as is reasonably possible… What is consistent are the general principles and lawful application of force, along with the use of prescribed techniques as taught during training. Adequate supervision and management of UOF incidents are covered in the syllabus and full details are in the UOF training manual and PSO 1600."

118. Furthermore, the practice at Brook House in relation to UoF training and accreditation was found by Mr Collier to be consistent with the underlying PSO:[145]

> "Local staff do attend an Initial Training Course of 32 hours (as described in PSO 1600) during their foundation training course, known as an ITC, and a further 8 hours refresher every 12 months (as described in PSI 30-2015157). They are assessed as competent, or not, and signed off to authorise them for operational duties. In the event that a member of staff does not complete a fresher course within the 12 month period they can continue in an operational role, however they are not permitted to be

[142] CJS000360_0006, para 2.1.1

[143] INQ000111_0013, para 29

[144] INQ000111_0145, paras 634-635

[145] INQ000111_0147, para 641

> deployed during a planned incident, and only used for unplanned incidents where there is an imminent risk of harm, until such time as currently accredited staff attend."

119. He added in his first supplementary report that: "*It is correct that staff whose UOF accreditation had lapsed could not take part in planned incidents.*"[146] It was not the case, for example, that officers were being used for planned interventions where their UoF accreditation had lapsed.

120. Indeed, Mr Collier – quite rightly it is suggested – appears to have taken into account that junior staff may well make some mistakes when transferring skills from the classroom to a live, operational environment: "*To a degree this is all part of the learning curve when staff are new into post*".[147] Indeed, where there is a relatively high turnover of staff, that increases the prevalence of less experienced staff participating in any particular use of force. In that regard, Mr Collier's suggestion of an extra refresher for course for new joiners, six months into the role appears to be an eminently sensible suggestion.[148]

121. Furthermore, the Inquiry heard evidence from officers, themselves, that UoF training prepared them, as best it reasonably could be expected to, for the types of incidents they would face in the IRC (as addressed further below). There was also evidence that lessons were learned from incidents, and this would be fed back to other staff through refresher training. For example, in relation to an incident on 31 May 2017 involving D149, Mr Collier described his concerns about the detained person being in the prone position.[149] In his oral evidence, Dave Webb explained that "*lessons have been learnt from that [incident] and the practice has been changed since*".[150] He went on to explain how, in light of the updated endorsed technique was rolled out to staff following that incident:[151]

> "It used to be the only option was of pretty much a full relocation, which is what you saw on the video there. When I went for my training course, they just adopted what they call a side relocation. Therefore, the detainee went on the floor. For want of a better description, was more in the recovery position, so therefore, not laying on his chest and obviously running any risks of other problems, and that obviously changed within the centre reasonably quickly after that – that incident. That came in a couple

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[146] INQ000158_0068, para 31.9

[147] INQ000111_0146, para 637

[148] INQ000111_0146

[149] INQ000111_0027, para 88

[150] David Webb 3 March 2022 158/1-4

[151] David Webb 3 March 2022 158/6-18

> of months, I would -- again, I'm guessing. I would say it was like a couple of months after that came in, where obviously everybody had to be trained in it."

122. There is a particular point raised (in various places) by Mr Collier in relation to the removal of PPE as a means of de-escalation (or not wearing some or all PPE for planned uses of force in some situations). G4S addresses that point below in the context of its submissions on the individual incidents. However, in short, while G4S recognises the force of Mr Collier's observations in this regard – it merely points out that PPE was expected to be worn for all planned use of force events per Annex F of PSO 1600, with no suggestion of this being partial, optional, or potentially removed during the course of an incident. If the Inquiry is minded to make a recommendation along the lines of Mr Collier's approach, that is a matter for the Chair, although in G4S' view this would require amendment to the governing PSO.

123. It is also correct for Mr Collier to observe that a substantial number of planned UoF events (and some unplanned) concern a detained person's removal from the United Kingdom.[152] G4S is not involved in this aspect of a detained person's case and the Inquiry will recall the evidence of various G4S officers who felt frustrated as 'middlemen' between detained persons who were concerned about their immigration case and their caseworkers. G4S understands from the evidence put to the Inquiry that the Home Office's practices since the Relevant Period have changed substantially in this regard so that detained persons have greater access to caseworkers and information about their case. It is unsurprising, however, given – as noted above – that for so many detained persons there primary consideration at Brook House was their immigration case, that this would be the cause of non-compliance with lawful instructions, in particular when it concerns the detained person's removal. G4S therefore encourages any steps that can be taken to better apprise detained persons in relation to developments with regard to their immigration case, including removal directions, including as a potential means to reduce the need for force to be used – e.g. if a detained person is able to understand and prepare for a planned removal.

124. Returning to the beginning on use of force, it is important for the Inquiry to see both the wood and the trees: to consider, in detail, any incidents where standards fell below those expected, but equally not to lose sight of the wider context – that staff were well-trained and did their best to applies those techniques in a dynamic and difficult operating environment. On the whole, Mr Collier saw practice that was good (albeit with some exceptions). More

[152] INQ000111_0150, para 646

than that, even where practice was not well-executed, it was at least well-intentioned: a relevant factor to the Article 3 analysis. Indeed, Mr Collier says in terms: "*With the exception of incident 105 (D1527) all other footage shows staff using, or attempting to use, appropriate authorised techniques*".[153]

125. Indeed, Mr Collier's reports read – as they should – not as a wholesale admonishment of an establishment gone rogue, where officers act with impunity and cause injury and humiliation to detained persons. On the contrary, it is a careful consideration of a catalogue of incidents, where the vast majority of criticism is tightly-focused analysis of the proper application of techniques, as applied from a manual and classroom to the 'field':[154]

> "Staff appear well versed in using the full range of restraints on the arms, and not relying fully on wrist flexion or pain inducing techniques. De-escalation of techniques is commonplace and demonstrates an awareness of only using necessary force and trying to avoid deliberately inflicting pain on a detainee".

126. That point is an important one: pain-inducing techniques (PIT) are a valid part of the DCO's arsenal, when deployed appropriately. Mr Collier's evidence is that there was no over-reliance on such techniques. Were Brook House a hotbed of abuse, or even somewhere where officers sought to inflict pain sadistically or gratuitously, Mr Collier would no doubt have witnessed a substantially greater prevalence of the use of PITs and – more importantly – obviously inappropriate use thereof. It is telling that he did not. Indeed, where Mr Collier did witness detained persons in pain because of a technique that had been misapplied, it was because of a mistaken application, not because of a desire to inflict hurt: "*I conclude that incompetence and not anything else was the reason for the small number of occasions when detainees appeared in pain or complained of excessive force*".[155] That is not to say that the Inquiry should glibly pass over such incidents. Any pain which could, in the future, be avoided through different training methods and practices is important to consider; but it is an entirely different proposition to abuse meted out at detained persons.

127. In short, G4S is grateful to the Inquiry for the opportunity to consider in detail, and with expert assistance, how use of force practices operated during the Relevant Period. No doubt, those practices are not without criticism – in particular in relation to how monitoring and oversight took place and how instances of the use of force were recorded. While there is, of

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[153] INQ000111_0157, para 661

[154] INQ000111_0157, para 661

[155] INQ000111_0159, para 667

course, room for improvement in a number of these areas, and G4S looks forward to learning from the recommendations that this Inquiry is likely to make in this regard, it submits that whatever constructive criticism can be made, these points were not directly causative of any harm (let alone mistreatment) suffered by detained persons during the Relevant Period.

Response to bullying or intimidation of detainees by other detainees

128. The key aspect of the complaints system available to detained persons was that there access to it was "*free and unfettered*".[156] Any all complaints received from a detained person (or from another person on their behalf or organisation) would be shared with the Home Office. The Home Office then determined whether the complaint would be investigated by its PSU or by G4S staff at Brook House. As CTI explained in opening:[157]

> "Complaints could be made by detained persons by various means, including verbally to a member of G4S or Home Office staff, to a member of the IMB, or by putting a written form into a yellow box at the centre. Additionally, people not in detention, such as friends or family members, NGOs and solicitors could raise concerns in writing with G4S or with the Home Office. Part of the Home Office's contract monitoring role involved ensuring that complaint forms were available in every residential unit and in the library. They were translated in up to 20 languages."

129. As considering of an example form shows[158], it clearly states: "*Please place completed form in the yellow immigration enforcement complaints box*". To avoid disincentivising complaints, the form also made clear that: "*The submission of a complaint will not affect consideration of your immigration status*". As Mr Brockington explains, "*the post box was accessible only by HO staff, who were responsible for collecting the post. The HO would then triage the complaint and make a determination as to whether the complaint should be dealt with locally at Brook House or PSU*".[159] There was, in addition, a further dedicated IMB complaints box on the residential wings, if a detained person wished to complaint to a completely independent body.

130. That is a healthy, well-constructed complaints system. The Home Office are independent of G4S staff; more than that – the Home Office would want to know and investigate if there were any allegations of mistreatment by its contractor. Operating a system in this manner

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[156] CJS0074041_0017, para 74

[157] Opening Statements 23 November 2021 64/12-23

[158] CJS001526_0002

[159] CJS0074041_0024

enables detained persons to essentially have a 'direct line' to the HO: one which: (a) could not be intercepted by G4S (as only the Home Office had access to the 'yellow box'); and (b) made clear that raising a complaint would not adversely impact a detained person's immigration case. Indeed, detained persons were clearly aware that not only that the complaint box existed, but also that complaints made through it would not be collected by the staff who may well be the subject of a complaint. In D1747's read-in evidence, he said: "*another detainee told D1747 about the locked yellow box and that complaints go straight to the Home Office, not detention centre staff*".[160]

131. Of course, it is to be expected that no system will work faultlessly on 100% of occasions – and Paul Gasson explained in his evidence in relation to D2953's complaint that "*one of the deputy immigration managers… should have read that complaint [and] know that one part of it would have gone to healthcare and part of it should have been sent to the desk complaints team.*"[161] Assuming that complaint was put in the 'yellow box', he described it as an "*oversight by the member of staff*".[162]

132. As demonstrated by G4S' submissions on the individual incidents below, considering the detail shows that what emerges from the pool of evidence is the position that – in the overwhelming majority of cases – where a detained person did make a complaint through the appropriate channel, it was properly investigated through that channel. Ultimately, G4S and the Home Office put in a place a robust complaints process: one that enabled detained persons to make complaints about what occurred at Brook House direct to the Home Office (in case they had any fear of repercussions from staff). That 'yellow box' process was used by some detained persons; and the evidence shows it was effective when used. There is no evidence to suggest that any detained person was victimised for making a complaint; or that staff sought to disincentivise or punish detained persons for raising complaints – and there was a yellow box on every residential wing. In the circumstances, therefore, detained persons had every opportunity to raise complaints and G4S cannot be held responsible for any case where a detained person opted not to raise a complaint through the recognised route.

133. Indeed, the work of the PSU should be recognised for its dedication and efforts in doggedly investigating the complaints that came before it – doing so with an open mind, without preconceptions and often on the basis of limited information in the first instance. That did

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[160] D1747 (read-in) 9 December 2021 162/7-9

[161] Paul Gasson 15 March 2022 186/2-6

[162] Paul Gasson 15 March 2022 187/12-13

not dissuade the PSU from undertaking detailed enquiries, often in circumstances in which a less dedicated unit could easily have closed off a complaint for lack of detail or information in the original form, or, in some cases, based on an ostensible lack of credibility in the account contained within the complaint. Nevertheless, even in cases where the PSU did ultimately find a complaint to be unsubstantiated; even in cases where the detained person's account was ultimately wholly rejected – the PSU did not reach this conclusion without a thorough investigation of the substance of the matter. The Inquiry will not be oblivious to the length of and level of detail contained within PSU reports: not only as an analysis of the underlying narrative and competing accounts, but also – constructively – containing recommendations for future practice as a result of the matters concluded.

Whistleblowing

134. The Inquiry has received extensive evidence on G4S's independent whistleblowing regime: see in particular Mr Petherick's[163] and Mr Brockington's[164] witness statements. In summary, G4S has a global whistleblowing policy known as "Speak Out" which was in place during the Relevant Period.[165] This was established with significant input from Public Concern at Work who were acknowledged experts in the whistleblowing field.[166] There was a dedicated phone number and webpage enabling employees to easily access it. The phone number and website were managed and overseen outside of the local management structure. Any "Speak Out" complaint was investigated by a senior member of G4S staff (Divisional Legal Counsel),[167] "outwith and independent of local reporting lines."[168] All whistleblowing complaints were reviewed on a monthly basis in the Divisional Ethics Committee which included Mr Neden.[169]

135. Mr Tulley, in his witness statement confirmed that after the undercover Panorama documentary on Medway STC, a senior member of G4S's management came to Brook

[163] Mr Petherick 1st ws, CJS0074047_0031-33.

[164] Mr Brockington's 1st ws, CJS0074041_0027-0030, paras 128-143. See also Mr Dove's witness statement, CJS0074040_0025-0027, paras 140-147 detailing whistleblowing in the healthcare context.

[165] CJS000707.

[166] Mr Brockington, 31 March 2022, 51/20-51/1.

[167] Mr Neden ws, INQ000119_0022, para 99

[168] Mr Petherick 1st ws, CJS0074047_0031, para 167.

[169] Mr Neden ws, INQ000119_0022, para 99.

House and explained to staff there the importance of utilising the "Speak Out" whistleblowing process if they witnessed unacceptable conduct.[170]

136. Mr Petherick confirmed that the whistleblowing process was utilised by a number of individuals at Brook House.[171] This was confirmed by Mr Neden who explained that *"at the point G4S was notified of the Panorama allegations, 11 matters had been referred to the group's Speak Out system in respect of Brook House."*[172] Whilst it is not in dispute that Mr Tulley,[173] failed to utilise the required whistleblowing process blaming the fact that "Speak Out" posters had been *"vandalised"* as his reason for this, this is not a plausible or cogent explanation for his failure given the fact that a significant number of other staff at Brook House felt able to utilise the "Speak Out" whistleblowing process. G4S took all reasonable steps to ensure that staff could utilise a whistleblowing procedure. The existence and structure of such a whistleblowing procedure did not cause or contribute to the mistreatment of detainees.

The 60 extra beds in 2017

137. The Inquiry's view on this issue, as evidenced by the questions asked by CTI, appears to be that G4S, motivated by a desire to increase profit increased the capacity of Brook House by 60 beds by converting 60 rooms that accommodated 2 persons to accommodating three persons when such an increase could not be safely carried out. Such a view is both simplistic and fundamentally wrong. G4S is a company rather than a public body or a charity. It has legal obligations to its shareholders to make a profit in the same way that SERCO, PPG and other companies engaged in the provision of custodial services have such legal obligations. The Government elected to contract out the running of Immigration Detention Centres to private companies. It is that decision (which is outside the scope of this Inquiry) that resulted in private companies, who all seek to make a profit, running Immigration Detention Centres.

138. The implicit suggestion that G4S somehow put profits ahead of properly caring for detainees when it decided to increase capacity is misconceived on a number of levels. Firstly, as both

[170] Mr Tulley 1st ws, INQ000052_0013, para 58.

[171] Mr Petherick 1st ws, CJS0074047_0033, para 175.

[172] Mr Neden ws, INQ000119_0023, para 105.

[173] And other members of staff who witnessed mistreatment of detainees but failed to report it.

Mr Skitt[174] and Mr Hanford[175] explained the decision to increase capacity was not G4S's but the Home Office's. As Mr Skitt clearly explained, the Home Office were G4S's customer and G4S were expected to provide what the customer requested. Mr Skitt's view, (which is correct) is that it was simply not open to G4S to simply refuse the request. Mr Skitt accurately described the extra bed decision as a "*directive from the Home Office*".[176]

139. Mr Hanford, in his oral evidence, explained that the Home Office had initially wanted 180 extra beds but that G4S has pushed back against this suggestion as they knew it was too much.[177] Of course, if as the Inquiry appears to suggest, G4S placed profit about detainee care and safety, it would have agreed to the Home Office's proposal. As Mr Hanford explained, the initial proposal to increase capacity came from the Home Office in 2014.[178] There was a tripartite assessment of risk (by the Home Office, Ministry of Justice Estates and G4S) which concluded that the proposal to increase capacity was viable.[179] That was a correct assessment based upon the detainee population present at Brook House in 2014. However, negotiations took a significant amount of time and by the time the additional 60 beds were added in 2017, the detainee population had fundamentally changed.[180] In particular:

(a) the percentage of detainees who were time served foreign national prisoners increased significantly in 2017. Such prisoners were bringing in prison learned behaviours which made the environment significantly more challenging;

(b) the average stay of detainees increased from 28 days in 2013/14 to 48 days in 2017.[181] Some detainees remained 13 or even 18 months. Detainees inevitably became increasingly frustrated, the longer they were detained as well as an increase in mental health

(c) A spice epidemic hit Brook House. As detailed elsewhere, Brook House was far from unique in this. Spice usage was causing serious problems throughout the custodial

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[174] Mr Skitt, 17 March 2022, 132/9-10

[175] Mr Hanford, 15 March 2022, 93/15-25

[176] Mr Skitt, 17 March 2022, 132/9-10

[177] Mr Hanford, 15 March 2022, 94/6-9. See also Mr Petherick 21 March 2022. 67/7-13.

[178] Mr Hanford, 15 March 2022, 94/15-17

[179] Mr Hanford, 15 March 2022, 99/18-100/6

[180] Mr Hanford, 15 March 2022, 94/19-100/24

[181] HMIP Report, Jan 2017, CJS000761_0005.

estate. However, the high level of spice usage and the associated attacks/overdoses placed increased pressure on Brook House and custodial and healthcare staff.

140. G4S maintains its position that the addition of the 60 beds did not contribute to or cause the mistreatment of detainees during the Relevant Period. However, to the extent that the Inquiry disagrees, responsibility for this resides solely with the Home Office who required additional capacity.

Healthcare

Introduction

141. A considerable amount of the Inquiry's focus during the hearings has been on healthcare provision. However, for reasons that are unclear, the Inquiry decided not to seek any evidence from any members of the Leadership Team in place at G4S Health Services in post at the relevant time. Thus, no witness evidence was obtained from:[182]

(a) Mr Tom Tuppen, Managing Director of G4S Health Services:

(b) Ms Angie Hill, Director of Nursing;

(c) Ms Angela Lennox, Medical Director;

(d) Ms Emma Moore, the COO of Health (until May 2017 when she went on maternity leave);

(e) Mr Jonathan Scott, Head of Operations;

(f) Ms Maxine York, Regional Quality Governance and Clinical Manager;

(g) Mr Peter Kolakowski (Senior Account Manager);

(h) Ms Helen Robinson, Head of Quality, Audit and Compliance.

142. Similarly, other than a brief witness statement from Mr Watkin, Head of NHS England Health and Justice, in the South East,[183] no witness evidence was obtained from the body commissioning Healthcare Services at Brook House, namely NHS England. It is notable that

[182] An Organisation Chart detailing the various individuals who had roles in the G4S Health Services Leadership Team was provided by G4S to the Inquiry: CJS005916_0001, so it was well aware of the individuals holding senior management roles and had the opportunity to contact them to obtain evidence if it so wished.

[183] NHS000054.

Mr Watkin's statement does not address what healthcare was commissioned from G4S Health (or PPG) at Brook House or NHS England's expectations as to the length of Rule 34 appointments or Rule 35 appointments. Thus, in contrast to the position in relation to the custodial contract with the Home Office, the Inquiry chose not to inform itself properly about or NHS England's contract and subsequent contract management.

143. The Inquiry's failure to gather such evidence is particularly problematic given the fact that almost all of these individuals have now left G4S Healthcare and thus G4S Healthcare are limited institutional knowledge of events at a senior management level during the Relevant Period.[184]

144. The commissioning arrangements and what was expected by the Commissioning Body (ie NHS England during the relevant period) are clearly relevant to a number of issues that the Inquiry is considering. For example, CTI suggested that Rule 34 required a "full" mental health and physical health assessment and 5/10 minutes was insufficient for such an assessment.[185] There is no evidence that the commissioning body was of the view that longer appointments were necessary or that the approach taken at Brook House during the Relevant Period and subsequently was erroneous (or different to that adopted elsewhere in the IRC estate). The commissioning both of G4S Health and PPG, appears to be based on the basis that such a short appointment was appropriate. If a longer appointment is necessary a discussion with the commissioning body would be required. Mr Wells of PPG explained that if their approach to Rule 34 assessments needed to change, a conversation would be needed with NHS England as the commissioning body.[186] If, as CTI appears to think, Rule 34 appointments should be a lot longer and should be a "full" mental and physical assessment, questions should have been asked of the commissioning body as to why the commissioning arrangements did not provide for a lengthy Rule 34 assessments and why, in the eight years that NHS England has been commissioning primary healthcare at Brook

[184] Mr Peter Kolakowski remains with the business.

[185] CTI's analysis of what Rule 34 requires is not accepted. See below at paragraphs 156-165.

[186] Luke Wells, 31 March 2022, 175/9-176/8. See also Luke Wells 31 March 2022, 191/24-192/17 in relation to extra provision.

House, it has never raised any concerns about the length of the Rule 34 assessments.[187] However, this issue was simply ignored by the Inquiry.

145. Further, it is important to bear in mind precisely what services were commissioned from G4S Health by NHS England. G4S Health were commissioned to provide primary but not secondary care services.[188] It thus did not include the provision of psychiatric services which were commissioned separately by NHS England.

Healthcare provision

146. The healthcare staff explained that the provision of primary healthcare at Brook House was equal to, or better than, an individual would receive in the community.[189] Detainees could see a nurse every morning without an appointment. Further, GP appointments could be booked the following day which is far better than the provision available in the community.[190] This view accords with that of the IMB which concluded in both its Annual report for 2016 and 2017 that detainees received care that equivalent to those in the community.[191]

Healthcare Staff Culture

147. Ms Calver explained in her witness statement that the healthcare team tried their best to create a caring compassionate culture at Brook House and to give detainees the treatment they required.[192] She developed this in her oral evidence explaining that healthcare staff referred to the persons detained as patients rather than detainees and did their upmost to meet the needs of such patients giving as much input as possible.[193] Ms Calver gave an example

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[187] NHS England appears to doubt the importance of such assessments. In the NHS England Health and Wellbeing Health Needs Assessment Programme: Immigration Removal Centres and Residential Short Term Holdings Facilities, National Summary Report, May 2015 at p 13, the report states *"The target for being seen by a GP [pursuant to Rule 34) may also be creating unnecessary demand for GP appointments and restricting access for detainees with more urgent needs."*

[188] See the 2014 Medical Services Contract: CJS0073871.

[189] See eg Ms Calver 1 March 2022 190/6-22.

[190] Ms Calver 1 March 2022 190/14-20.

[191] Annual Report for 2017, IMB000135_0017 and 2016 report: IMB000121_0011.

[192] Ms Calver 1st ws, DWF000009_0002

[193] Ms Calver 1 March 2022 208/6-19.

of such positive culture namely health promotion calendars which were used to ensure that Brook House's health services were provided for the benefit of patients then resident in Brook House.[194]

148. Whilst there were occasional inappropriate comments made by healthcare staff to intoxicated detainees, such inappropriate comments were rare and not reflective of the general culture. The spice epidemic during the relevant period placed huge pressures on healthcare staff which perhaps explains, albeit of course does not excuse, such occasional wholly inappropriate comments. As Mr Syred noted, "*most of the healthcare staff were very committed and professional*"[195] and the *"mental health team were brilliant, and very approachable…* "[196]

149. G4S of course accepts that Jo Buss' comments to D1527 about being *"an arse"* were wholly inappropriate. Ms Calver explained that she was horrified by Ms Buss' comment: such horror clearly indicates that such language was not part of, but was wholly inconsistent with, healthcare staff culture at Brook House.[197] In such circumstances, there is no basis upon which the Inquiry can conclude that the Healthcare staff culture caused or contributed to the mistreatment of detainees.

Healthcare Staff training

150. Details of healthcare staff training are set out in Ms Calver's first witness statement at paragraphs 14-22.[198] Mr Dove also provides details of the staff induction and training at paragraphs 46-67 of his first witness statement.[199] Ms Churcher at paragraphs 14-20 of her first statement details the training that she received including a two week induction.[200] Ms Churcher confirms that the induction training adequately prepared her for the role. Ms Churcher also confirmed that she also received Mental Capacity Act training, Prevent training and Administration of Medication Training.[201] G4S submit, subject to the issue of

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[194] Ms Calver 1 March 2022 144/20-145/1.

[195] Mr Syred 1st ws, INN000007_028, para 116.

[196] Mr Syred 1st ws, INN000007_028, para 116.

[197] Ms Calver 1 March 2022 147/8-13.

[198] Ms Calver 1st ws, DWF000009_0004-5.

[199] Mr Dove first ws, CJS0074040_0009-12.

[200] Ms Churcher 1st ws, DWF000003_003.

[201] Ms Churcher 2nd ws, DWF000022_004, para 12-13.

training on Home Office polices and rules addressed below, the evidence that the Inquiry has receives demonstrates that G4S provided adequate training to healthcare staff.

151. It was a recurring theme of the healthcare witnesses that they felt that the Home Office should have provided more training on its policies and rules including Rule 34, 35, ACDT and the Adults at Risk Policy. For example, Ms Churcher suggested that annual Home Office training should have been offered.[202] Similarly, Ms Calver explained that there were real challenges obtaining training from the Home Office. [203]

152. G4S agree with Dr Hard's analysis that, in relation to training on Home Office policies and key Detention Centre Rules, such training was for the Home Office to provide.[204] Further, the Home Office failed to provide the level of training required notwithstanding repeated requests prior to the Relevant Period.[205] The failure by the Home Office to provide such training to healthcare staff and GPs is, G4S submit, something that the Inquiry should take into account, when considering the level of culpability, if it concludes that G4S healthcare staff have failed to follow Home Office policies.

Staffing levels

153. Recruitment of healthcare staff at Brook House has always been challenging. The proximity to London means that nurses can earn more money in less stressful environments. As a result, G4S Health has had to rely upon agency staff. However, as Ms Calver explained such agency staff were experienced at working at Brook House: they had experience in security settings and the necessary security clearance. Ms Calver confirms that during the Relevant Period healthcare was fully staffed with a combination of contracted staff and agency staff.[206] In such circumstances, there is no basis for concluding that staffing levels in healthcare caused or contributed in any way to the mistreatment of detainees.

Alleged "culture of disbelief"

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[202] Ms Churcher 1st ws, DWF000003_003, para 18.

[203] Ms Calver second witness statement, DWF000016_0007, para 34; Ms Calver 1 March 2022, 226/3-21, 231/1-6.

[204] Dr Hard supplementary expert report, INQ000112_0053-0055.

[205] Dr Hard supplementary expert report, INQ000112_0053.

[206] Ms Calver 1st witness statement DWF000009_008-010, paras 42-51.

154. It was suggested that a number of healthcare witnesses that there was a "culture of disbelief" within healthcare at Brook House[207] The basis for this suggestion was said to be Mr Shaw's 2016 report. Mr Shaw addresses that at paragraph 7.53 where he states:

> "The Royal College of Midwives was among those referring to a culture of disbelief amongst detention centre staff, whereby detainees' symptoms or health complaints were viewed with suspicion. Women for Refugee Women said that: "In spite of the high levels of health support needs, the women we interviewed pointed to the clear inadequacies of the healthcare provided in detention…Two thirds said they did not trust the medical staff in detention; above all, women spoke about how the healthcare staff in detention appear to subscribe to a culture of disbelief."….[208]

155. However, it is clear that the quotes in the Shaw report they do not relate to Brook House. Both quotes concern the treatment of woman and, as the Inquiry is well aware, BH has never housed female detainees. Thus, the Shaw Report does not provide evidence of a "culture of disbelief" within healthcare at Brook House. In such circumstances, the consistent denials of healthcare staff as to the existence of a culture of disbelief should be accepted.

Rule 34 of the Detention Centre Rules 2001

156. Rule 34 of the Detention Centre Rules is entitled "medical examination upon admission and thereafter". Rule 34(1) provides that every detained person shall be given "a physical and mental examination" by a medical practitioner (ie a GP) within 24 hours of his admission to the detention centre. Rule 34(2) makes clear that such an examination is voluntary: if the detained person does not wish to be examined at this time, he may decline although he can subsequently request such an examination and, if such a request is made, he must be so examined, see Rule 34(3). As Ms Calver made clear, it is very common for newly arrived detainees to decline a Rule 34 medical examination as often, in the first 24 hours, their focus is on speaking to their lawyers about their immigration status and the possibility of release.[209] She further explained that detainees had a Rule 34 assessment booked within 24 hours of arrival but there were a large number of DNAs (do not attends).[210] Whilst G4S accepts that the Detainee Reception & Departures policy suggested that a doctor's appointment was not

[207] Eg to Ms Calver, 1 March 2022 148/11-149/3.

[208] Shaw Report 2016, INQ000060_0169-170.

[209] Ms Calver's Verita Interview, VER000275_004, Q and A 33-38.

[210] Ms Calver 1 March 2022 208/13-15.

always required within 24 hours,[211] that was not a healthcare document and did not reflect practice within healthcare. Dr Bromley confirmed that non-attendance at Rule 34 appointments at Brook House was still high.[212] Thus, the mere fact that a detainee was not seen by a GP within 24 hours does not mean that there is a breach of Rule 34 as he may very well have initially declined a medical assessment (or simply not attended the appointment).

157. Ms Schleicher asserts in her second witness statement, that, on occasion, Rule 34 assessments were not carried out within 24 hrs.[213] However, at no point does she acknowledge that the detainee must consent to such an assessment and that an unwillingness to have an assessment on the first day of arrival (when they are likely to have other priorities) may well be the explanation for absence of such an assessment within the 24 hour period. Ms Schleicher details four examples where she alleges that Rule 34 was breached albeit two of the detainees in questions were seen by a GP within 24 hours. One example is anonymous (MJ98375) and in relation to that individual it appears they were seen by a GP within 24 hours. Ms Schleicher asserts that this individual did not have "a physical and mental examination" although it is entirely unclear on what basis this assertion is made. It is obviously not possible to investigate the accuracy of this assertion given the fact that neither G4S nor the Inquiry know the identity of the individual concerned.

158. In relation to D1318, Ms Schleicher accepts that he was seen by a GP (Dr Oozeerally) within 24 hours although she suggests that the necessary mental and physical examination was not carried out because the assessment was "extremely brief". However, as detailed below, there is no minimum length of time required for a Rule 34 appointment In relation to the other two detainee examples: D668 and D2567, whilst these detainees were not seen by a GP within 24 hours, as detailed above, this does not mean that there was a breach of Rule 34. It is likely that the reason D668 and D2567 were not seen for a Rule 34 appointment within 24 hours is that they did not initially consent to such an examination as was their right or simply did not attend the appointment.

159. Dr Oozeerally confirmed that Rule 34 medical assessments were invariably completed by a GP within 24 hours of arrival where such an assessment was not declined.[214] Such an assessment was in additional to the healthcare initial screening which was carried out by a

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[211] G4S Detainee Reception & Departures, Brook House Policies CJS006945_21.

[212] Dr Bromley, PPG000172_0002 para 5.

[213] Ms Schleicher BHM000031_0015-16 paras 46-47

[214] Dr Oozeerally 11 March 2022 8/9-16.

nurse or healthcare assistant (under the supervision of a nurse) within 2 hours of arrival.[215] This initial screening addressed physical health, mental health, vaccination background, medication background, any previous history of self-harm and whether they had previously been subject to torture.[216]

160. Rule 34 says nothing about the necessary length of the medical assessment carried out by the GP just that it is to be a physical and mental assessment. CTI repeatedly suggested to witnesses that Rule 34 required a "full" physical and mental health assessment however the word "full" appears nowhere in the text of Rule 34 and has simply been wrongly inserted by CTI. Rule 34 has to be construed in a common sense manner taking into account the relevant context. The relevant context includes the fact that the requirement is for the assessment to be carried out within a very short period after arrival (24 hrs) and the large number of detainees arriving at Brook House (and other IRCs) each day: The Gatwick IRC Brook House Health Needs Assessment records that there were approximately 6500 detainees arriving over the 12 month period of May 2016 to April 2017 which amounts to over 500 a month or, on average, 18 arrivals per day.[217] As Ms Calver explained in her oral evidence, a 20 minute appointment would not be possible given the vast number of detainees that can arrive in a day as "the doctors would be there 24 hrs a day".[218]

161. Given the large volume of arrivals (at Brook House and other IRCs) and the short time limit for completion of the assessment, a *"full"* mental and physical examination lasting 45 minutes to an hour (or even 20 minutes) is simply no possible. The context of Rule 34 thus suggests that what is required is a brief initial assessment with follow up appointments with GPs scheduled if necessary. This is what occurred at Brook House during the Relevant Period and subsequently (as well as, no doubt, other IRCs) and was sufficient to comply with the requirements of Rule 34.

162. Ms Calver in her Verita interview made reference to the fact that such Rule 34 appointments were booked for 5 minutes.[219] However Dr Oozeerally explained in his oral evidence this did not mean that every appointment lasted only five minutes particularly given the large number of detainees not attending their scheduled appointment: some were longer depending

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[215] Ms Calver first ws, DWF000009_0011, para 61.

[216] Ms Calver, 1 March 2022 159/4-7.

[217] NHS000001_0001_0006.

[218] Ms Calver 1 March 2022 209/1-6.

[219] VER000275_0004, Answer 36.

on the detainee's particular health issues[220] Ms Calver confirmed that the approach adopted at Brook House was the same as at other Detention Centres.[221]

163. Brook House's approach (initial screening plus GP appointment with 24 hrs of arrival) was sufficient to fulfil purpose of Rule namely to identify immediate and significant mental or physical needs, and whether they have been victims of torture. Ms Schleicher suggests that if there is reference to torture or other harms, there should be an immediate Rule 35 report.[222] There is no basis for that suggestion. Rule 35, unlike Rule 34, does not prescribe a time by which the report should be completed. Detention Services Order 09/2016 suggests that where a detainee states he has been tortured, an appointment should be made with a GP *"as quickly as possible."* There is no suggestion that a Rule 34 assessment should be converted to a Rule 35 assessment. The DSO does not suggest that the GP appointment to prepare a Rule 35 appointment should be prepared "immediately". The reference to such an appointment being made "as quickly as possible" recognises that, because of the limited resources in healthcare (which is the case not just in Brook House but in the NHS nationally) and the numerous demands on GP's time, such an assessment may well not happen immediately.

164. Dr Hard, in his written expert reports, agreed that G4S Health had complied with the requirements of Rule 34.[223] Whilst G4S accept that his oral evidence on this issue was different, that was because CTI incorrectly suggested to him that a "full" physical and mental health assessment was required.

165. In any event, whatever the correct interpretation of Rule 34, there is absolutely no basis upon which the Inquiry can conclude that a failure to comply with Rule 34 caused or contributed to the mistreatment of detainees. This accords with Dr Hard's expert view as set out in his written reports.[224] As set out below, it is clear that even if both Rule 34 and 35 had been fully complied with on every occasion, there is no basis for concluding that any mistreatment would not have occurred given the very low level of release upon the submission of Rule 35 reports (both from GPs at Brook House and elsewhere in the IRC estate).

Rule 35

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[220] Dr Oozeerally 11 March 2022 8/20-9/8,

[221] Ms Calver 1 March 2022 209/1-6

[222] Ms Schleicher 1st ws at para 40 BHM000032_0012

[223] INQ000075_0170 (para 6.2.2.8) and INQ000112_0013.

[224] INQ000112_0009.

166. G4S accept that during the Relevant Period (and indeed both before and after the Relevant Period) the approach adopted by the healthcare staff, and in particular, the GPs did not accord with the clear language of Rule 35 of the Detention Centre Rules 2001. Further, G4S accept that there was a failure to complete reports under the first two limbs of Rule 35 when detainees met the criteria under these two limbs on numerous occasions. G4S also accept that the quality of the Rule 35 reports that were completed by the GPs was variable. The Inquiry will need to determine where primary responsibility for these failures lie. When considering this issue the Inquiry will no doubt bear in mind a number of matters.

167. First, the number of Rule 35(1) and (2) reports completed at Brook House during the Relevant Period was not dissimilar to the number completed at other IRCs at this time.[225] As Ms Calver explained, in the IRC Forum she set up which was attended by representatives of other IRCs as well as the Home Office, there was a shared understanding in relation to the thresholds to be applied to the various limits of Rule 35.[226] Ms Calver expressly confirmed that the Home Office was content with the thresholds being applied.[227] Further, it appears from the oral evidence to the Inquiry that five years later, under the new provider PPG, nothing has really changed.[228]

168. Secondly, the relevant Home Office Guidance namely DSO 09/2016 focusses to a considerable extent on Rule 35(3) 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"[229]

169. However, there is no such guidance to healthcare on the first two limbs of Rule 35. The DSO reinforces the importance of Rule 35(3) in comparison with the first two limbs of the rule.

170. Thirdly, healthcare staff and G4S raised the lack of training on Rule 35 with the Home Office on more than one occasion, however, there were real challenges obtaining such training from

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[225] See Ms Schleicher first ws, BHM000032_0050, para 146.

[226] Ms Calver 1 March 2022, 220/20-14.

[227] Ms Calver 1 March 2022, 220/15-19.

[228] Dr Oozeerally, 11 March 2022, 84/23-85/4.

[229] DSO 09/2016 HOM002591_0007.

the Home Office.[230] This was not a new problem nor does it appear to be limited to Brook House. Stephen Shaw in his 2016 report at para 4.116 noted that one of the concerns healthcare staff at the IRCs generally had was that "*on site teams were not sufficiently trained to complete them.*"[231] Dr Hard is rightly very critical of the Home Office's failure to provide training to GPs and other healthcare staff. He makes clear that the responsibility for providing such training lay with the Home Office rather than the GPs themselves, G4S or NHS England.[232] Dr Hard suggests that in the absence of group training, the Home Office should have organised 1:1 training for GPs at an interim measure.[233] Dr Hard noted that, like the DSO, the limited training materials that he saw focus on Rule 35(3) and did not cover Rule 35(1) and Rule 35 (2) in any detail.[234] This accorded with Ms Calver's oral evidence that the limited training on Rule 35 provided prior to 2017 was *"more torture awareness"* rather than a discussion of the three limits of Rule 35.[235] Given the lack of any training on Rule 35(1) and (2) and the consistent emphasis on Rule 35(3) in the DSO it is perhaps unsurprising that there were very few Rule 35(1) and (2) reports were completed.

171. Fourthly, 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.[236] Further, the Home Office did not raise concerns about the content or quality of the Rule 35 reports that were completed so the GPs were not to know that there were a problem either with the content of the reports or the low number of Rule 35(1) and (2) reports.[237] Ms Calver confirmed that she has raised the issue of quality audits with the Home Office policy team however, the Home Office did nothing in response.[238] Dr Hard, in his supplementary report, made clear that he would expect the Home Office to, *"have a*

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[230] Ms Calver second witness statement, DWF000016_0007, para 34; Ms Calver 1 March 2022, 226/3-21, 231/1-6.

[231] Shaw Report 2016, INQ000060_0108.

[232] Dr Hard Supplementary report INQ000112_0053.

[233] Dr Hard Supplementary report INQ000112_0055.

[234] Dr Hard Supplementary report INQ000112_0054.

[235] Ms Calver 1 March 2022, 152/6-11

[236] Ms Calver, 1 March 2022, 227/24-228/9.

[237] Ms Calver, 1 March 2022, 227/13-23.

[238] Ms Calver first ws, DWF000009_0021, para 125.

mechanism for quality assessment and assurance of the reporting process in order to make sure that continuous quality improvement activities were being undertaken." [239] However, no such mechanism existed during the Relevant Period (or subsequently).

172. Fifthly, Ms Calver, in her oral evidence to the Inquiry, explained that she has set up an IRC forum to discuss Rule 35 issues with the other IRCs. The Home Office attended this forum and approved the Rule 35(2) pathway drafted by Ms Calver. [240] Ms Calver understood that, as a result of the Home Office approval, this pathway document was rolled out elsewhere in the IRC estate.

173. Sixthly, the Home Office encouraged GPs to use Part Cs to report cases of attempted suicide and self-harm rather than write a Rule 35(2) report. Mr Cheeseman in his oral evidence stated:

> "I was aware that the ACDT process had effectively- well, ran alongside rule 35(2) but had in some ways kind of replaced the reporting need because Part C's were used to report cases of suicide and self-harm, of suicidal ideation and self-harm and that any conversation needed by caseworks to consider cases under the Adults at Risk, policy would be getting through through Part Cs or by other communication methods."[241] (emphasis added)

174. This is consistent with the approach adopted by, inter alia, Dr Oozeerally. He understood that a Part C report was the best way to communicate with Home Office particularly when the matter was urgent.[242] Ms Calver had a similar understanding: in her oral evidence she noted that it often took 48 hours for the Home Office to respond to a Rule 35(1) report but that writing a Part C would often get a faster response *"and then [the] patient could maybe released or put in-appropriately moved by that Part C."*[243] Whilst G4S of course accept that a Rule 35 report formally triggers a review of detention and a Part C report does not, it is clear from the practice that Rule 35 reports rarely led to release and a practice had developed with the knowledge and approval of the Home Office for GPs to communication with them via Part C reports rather than Rule 35(2) reports.

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[239] INQ000112_0055.

[240] Ms Calver 1 March 2022, 220/15-19.

[241] Mr Cheeseman, 16 March 2022 200/25-201/7.

[242] Dr Oozeerally, 11 March 2022, 52/2-23

[243] Ms Calver 1 March 2022, 74/24-275/2.

175. When considering whether the failure to complete Rule 35 reports on every occasion that the threshold set out in Rule 35 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 10-20%.[244]

176. G4S submits that given such a low acceptance rate (both in relation to Brook House and more generally) during the Relevant Period it is simply not possible to conclude that any failure to complete a Rule 35 report correctly or at all caused or contributed to the mistreatment of detainees. Furthermore, the variable quality of the reports also did not have a causative impact on the failure to obtain release and/or the mistreatment of detainees: at paragraph 4.109 of his 2016 report, Mr Shaw stated:

> "Dr Frank Arnold provided an analysis of people held in DFT where a rule 35 report was submitted. He argued that resistance to release by the Home Office "was evidence irrespective of the quality of the rule 35 reports…Excellent reports were as likely to be rejected as poor ones, often for reasons which were not compliant with Home Office policy."[245]

177. It is clear that Rule 35 was being applied incorrectly throughout the IRC estate during the Relevant Period and subsequently. Brook House's approach to Rule 35 during the relevant period was consistent with the approach adopted elsewhere. The Home Office were well aware of the thresholds being applied at Brook House and throughout the IRC estate; the Home Office approved the approach adopted. Mr Shaw in his 2016 report identified that the Home Office as responsible for this failure in relation to the flawed operation of Rule 35; he recommended urgent reform of the Rule 35 mechanism[246] which unfortunately, did not happen.

E Wing

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[244] The evidence suggests that the Rule 35(3) reports from Brook House resulted in a higher rate of release when compared to the IRC estate generally. In 2017, 18.1% of Rule 35(3) reports led to release: see Ms Schleicher first ws, BHM000032_0050, para 146. However, during the same year, 26.8% of Rule 35(3) reports at Brook House led to release: See Ms Schleicher first ws, BHM000032_0052, para 151.

[245] Shaw Report 2016, INQ000060_0104.

[246] Shaw Report 2016, INQ000060_0106.

178. E Wing contains 13 bedrooms. It also has 2 rooms that can be used for constant observations. It is smaller than the other wings and has a higher staff to detainee ratio.[247] The functions of E Wing include:

- To accommodate detainees at high risk of self-harm for observation in line with the local ACDT policy.
- For detainees with any medical or mental health concerns where it is deemed by medical practitioners that it would be the most suitable location…[248]

179. Whilst some detainees were transferred to E Wing prior to removal, if there was a concern that they may attempt to disrupt removal however, Ms Calver confirmed that the most refractory of those detainees intent on disrupting removal would be placed in the CSU rather than E Wing.[249] E Wing's size and greater number of staff meant that it was easier to manage detainees who were unwell. Ms Calver described E Wing as "the calmer wing".[250] It was also generally quieter than the other wings which were usually very noisy.[251]

180. Healthcare staff, including a GP, would visit on a daily basis including a GP.[252] Ms Churcher explained:

> "We [ie healthcare staff] were very involved with the detainees on E-Wing. We would go to E-Wing every day and administer the medication for those that were not allowed off the wing. We would review the constant observation detainees every morning and we would review the detainees in the close supervision units once a day."[253]

181. Contrary to CTI's suggestion, detainees located in E Wing were not informally removed from association. This was the case even if the detainees were on constant watch: Ms Calver in her oral evidence explained that such detainees could attend the library or the gym if they

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[247] Ms Calver's first witness statement DWF000009_016, para 95. See also HMIP Report on Brook House Oct-Nov 2016: CJS000761_0014, para S10 which refers to the *"staff-detainee ratio"* on E-Wing as being "*appropriately high*".

[248] E Wing Policy, CJS006043_004.

[249] Ms Calver, 1 March 2022 166/16-20.

[250] Ms Calver, 1 March 2022 166/2.

[251] Ms Calver, 1 March 2022 170/9-14.

[252] Ms Calver's first witness statement DWF000009_016, para 96.

[253] Ms Churcher 1st witness statement, DWF000003_0012-0013, para 87.

wished accompanied by an officer.[254] This evidence is consistent with the E Wing Policy which states:

> "Detainees who are located in E Wing will have full freedom of movement and association within the unit and the remainder of the centre unless they are subject to restrictions as a result of the use of rule 40/42 or medical needs."[255]

182. The basis for CTI's assumption that location in E Wing amounts to a *"de facto form of the Rule 40 segregation"* appears to be derived from Ms Schleicher's second witness statement where at para 86, Ms Schleicher states:

> " It[s] know from litigation in the cases of *R (MA and BB) v Secretary of State for the Home Department* [2019] EWHC 1523 (Admin) that E Wing was used by Brook House as a de facto form of the Rule 40 segregation".[256]

183. However, this is simply incorrect. There is nothing in May J's judgment that suggests placement in E Wing amounts to *"de facto segregation"*. This was not an issue upon which May J was asked to determine. The closest that the judgment in *MA and BB* comes to supporting this proposition is paragraph 24(15) which details MA's allegations:

> "MA was repeatedly put into isolation and removed from association without appropriate justification, and without appropriate notifications being given to MA within 2 hours (or at all) under rule 40(6) of the Rules, nor to the Secretary of State nor to a member of the visiting committee, in further breach of rule 40 of the rules".

184. The mere fact that MA alleges something in a document of course does not make it so. However, in any event, the allegation is not an allegation *that "E Wing was used by Brook House as a de facto form of the Rule 40 segregation"* but that notification was not given in accordance with the terms of Rule 40 which is fundamentally different. CTI's repeated reliance on the non-expert opinion evidence of the Medical Justice witnesses has again led the Inquiry into error.

185. CTI suggested to Dr Hard that transfer of detainees with mental health issues to E Wing was done in order to manage risks rather than to receive therapeutic input. G4S broadly accepts this suggestion. Ms Calver explained that it was not possible to provide Cognitive Behavioural Therapy or other similar mental health treatment at Brook House or other IRCs

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[254] Ms Calver, 1 March 2022 165/4-9 and 167/22-168/2.

[255] CJS006043_0004.

[256] Ms Schleicher 2nd ws, BHM000031_0035.

as they are not appropriate therapeutic environments.[257] However, that does not mean that such a location was inappropriate. The staff at Brook House were seeking to keep detainees safe. They were better able to do this on E Wing than the other wings because of, inter alia, the higher staff ratio and greater involvement of healthcare. The calmer and quieter environment on E Wing was generally better for such detainees that the noisy and busy standard wings. Detainees subject to constant or frequent watch could not be safely located on the standard wings given the hidden areas in the room and the need to lock doors at certain times.[258] The Inquiry may well conclude that Immigration Removal Centres are no place for individuals with mental health conditions in accordance with the Royal College of Psychiatrists' positon statement and the evidence of the various Medical Justice witnesses. However, during the Relevant Period there was very limited options available for mentally ill detainees. There was no in-patient facilities at Brook House. It was very difficult to transfer detainees to in-patient beds in hospitals: the IMB report for 2016 noted that:

> "There were only two transfers to mental health establishments in 2016, one to a local hospital and one to a medium secure unit, both experiencing significant delays owing to the difficulty in locating a bed."[259]

186. Whilst G4S accepts that GPs should have completed more Rule 35(1) and (2) reports in relation to such detainees, as detailed above, it is clear that even if such reports had been completed it unlikely that the majority would have led to release given the Home Office's apparent lack of trust in such reports and their refusal to release detainees in the vast majority of cases.

Rule 40: Removal from association

187. Rule 40 of the Detention Centre Rules 2001 concerns removal from association. A detained person may be removed from association with other detainees *"where it appears necessary in the interests of security or safety"*. This includes not only the safety of other detainees and staff but also the detainee subject to removal from association. Rule 40(1) provides that the Secretary of State's (or officer acting on her behalf by virtue of the *Carltona* doctrine) authority is usually required for such a removal. Rule 40(2) provides that in cases of urgency, the manager of a contracted-out detention centre may authorise removal from

[257] Ms Calver, 1 March 2022 165/4-9 and 167/22-168/2.

[258] Ms Calver, 1 March 2022, 164/24-165/4.

[259] IMB Annual Report 2016, IMB000121_0012.

association. Rule 65 provides that the manager of a detention centre may, *"with the leave of the Secretary of State"* delegate any of his/her powers under these Rules to another officer of that detention centre.

188. The authority for persons other than the Director of Brook House to authorise removals under Rule 40 and 42 are set out in DCO 02/2017 which provides the necessary leave of the Secretary of State for the purposes of Rule 65 of the Detention Centre Rules 2001. In particular, paragraphs 31 and 32 state:

> 31. In no circumstances must an initial authorisation be given for a period beyond 24 hours. In normal circumstances, any use of Rule 40 or 42, for an initial 24 hour period must be authorised by a manager (Executive Officer or above) from the HOIE IRC Team in a contracted out centre. In the case of an HM Prison and Probation Service (HMPPS) run centre, this initial authorisation can be provided by the centre manager or duty manager, who must then notify the HOIE IRC team as soon as operationally possible. Recording point: The person authorising the initial (24 hours) use of Rule 40/42 must record their authorisation on the form at Annex B boxes 10 – 15 and confirm that they have notified the HOIE IRC team.
>
> 32. In cases of urgency and if the circumstances are such that it is impracticable to seek the authority required in paragraph 31 in advance, the centre/duty manager (in a contracted out or HMPPS run centre) can make the emergency authorisation so that the authority is considered to begin at that point. In such circumstances, the HOIE IRC manager (or the HOIE on-call manager if out of hours) must be notified immediately. (emphasis added)

189. The relevant Duty Manager, who could be a DCM, was thus entitled to authorise removal for segregation in urgent situations although such authorisation would only have effect for up to 24 hrs. Thus, at most, G4S staff were responsible for the first 24 hours' segregation. Any further segregation of detainees beyond the 24 hour period was authorised by the Home Office alone.

190. Whilst G4S accept that research suggests that segregation can be associated with worsening mental health conditions, as Dr Hard made clear, in rejecting the proposition forcefully put to him by CTI that segregation was necessarily inappropriate, segregation of mentally ill detainees is sometimes appropriate. Dr Hard stated:

> "…I can also see, and in my experience working on the prison side, segregation sometimes for some people has, for them, in a way, a protective factor because it takes them away from an environment where they feel threatened. So it can give a bit of a closer eye on things…."[260]

[260] Dr Hard, 28 March 2022, 64/4-9

191. The majority of detainees subject to Rule 40 were located in the Care and Separation Unit ("CSU"). The Care and Separation Unit was initially a large unit with 13 rooms. However, in 2011, it was reduced in size because Mr Petherick was concerned that if a large unit existed for detainees removed from association, there was a risk that it would be filled with detainees subject to the removal from association.[261] On occasion, persons subject to removal from association were located in E Wing.

192. G4S does not accept that Rule 40 was misused or caused or contributed to any mistreatment of detainees. To the extent that the Inquiry disagrees, responsibility for this lies with the Home Office rather than G4S because, other than on occasions a short period of no more than 24 hrs, any such removal from association was their decision and not G4S.

SUBMISSIONS ON ARTICLE 3 AND THE SCHEDULE OF INCIDENTS

Introduction

193. The Inquiry's Terms of Reference ("**ToR**") set out that its purpose, amongst other things, is to "*reach conclusions with regard to the treatment of detainees where there is credible evidence of mistreatment contrary to Article 3 ECHR, namely torture, inhuman or degrading treatment, or punishment*". Under those ToR, 'mistreatment' is used to refer to: "*treatment that is contrary to Article 3 ECHR, namely to torture or to inhuman or degrading treatment or punishment*".

194. As a result, the core of the Inquiry's function is to "*reach conclusions*" where there is "*credible evidence of mistreatment contrary to Article 3 ECHR*". An important distinction is to be drawn, however, between the procedural limb of Article 3 which the UK discharges (in part) through this Inquiry; and any potentially substantive findings of a breach of Article 3 ECHR. Indeed, the ToR rightly define 'mistreatment' by reference to Article 3 ECHR because the role of the Inquiry is (amongst other things) to make factual findings as to whether there has been mistreatment, where there is credible evidence of Article 3 breaches. That is unsurprising and entirely appropriate, given its own origins in the decision of May J

[261] Mr Petherick, 21 March 2022, 33/7-34/11.

in *R (MA, BB) v Secretary of State for the Home Department* [2019] EWHC 1523 (Admin).[262]

195. That is not so say, however, that the role of the Inquiry is to make findings as to whether there have been substantive breaches of Article 3 (and, of course, the Inquiry is required to read the ToR compatibly with section 2, as in *In the matter of an application by Steven Davis & ors for judicial review* [2017] NIQB 126 at ¶15-20):

(a) First and foremost, to do so would be unlawful. Section 2(1) of the Inquiries Act 2005 ("**the 2005 Act**") prohibits it from doing so, in providing: "*An inquiry panel is not to rule on, and has no power to determine, any person's civil or criminal liability.*" By section 2(2), the Inquiry "*is not to be inhibited in the discharge of its functions by any likelihood of liability being inferred from facts that it determines or recommendations that it makes*". As a result, the Inquiry is not constrained in the factual findings it makes (e.g. in relation to particular incidents), but it is prohibited from drawing any legal conclusions – e.g. that any particular conduct (however egregious) was in breach of Article 3 ECHR.

(b) Section 2(1) of the 2005 Act mirrors the equivalent provision in relation to coronial inquests, found in section 10(2) of the Coroners and Justice Act 2009. As a result of section 10(2), the Chief Coroner's Guidance No. 17 in relation to *Conclusions Short Form and Narrative* states at paragraph 36:

> "Words denoting causation such as 'because' and 'contributed to' are permissible. 19 On the other hand, words which suggest civil liability such as 'negligence', 'breach of duty', breach of Article 2' and 'careless' are not permitted as they may breach Section 10(2) of the 2009 Act" (emphasis added).

The same applies here, *mutatis mutandis*.

(c) In the coronial context, the Court has expressly pointed out that simply because the inquest engages the procedural limb of Article 2 ECHR, not only does that not require the coroner to determine whether there has been a substantive breach of Article 2, but to do so would breach rule 42(b) of the Coroners Rules 1984 (the predecessor to s.

[262] It was conceded in *MA, BB* by the Secretary of State that the claimants' allegations concerning their alleged treatment at Brook House "*prima facie engages an obligation to investigate under Article 3*" (¶38) and so the judicial review judgment does not engage with the substance of the allegations and their relationship with Article 3.

10(2). In *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2008] 3 WLR 1284 Collins J put it thus at ¶23-24:

> "23. …On the last day of the inquest, the coroner asked for argument whether the evidence justified a finding that there was even arguably a breach of article 2 . He decided that no such finding was justified. It seems he thought that a conclusion on this was needed since it would dictate the contents and form of the verdict he would announce.
>
> 24. In my view, he was wrong to entertain the argument. The procedural obligation under article 2 was to hold the necessary inquiry and to find the necessary facts. If those facts showed that there was no breach of the substantive obligation and that nothing different need be done in the future to protect life, that should be indicated by the verdict. The family needed to know what were the conclusions on the important issues. Thus the inquest is not the means whereby a substantive breach of article 2 is to be established—indeed, as will become apparent, a verdict which appeared to determine this would be likely to be contrary to rule 42(b) of the Coroners Rules 1984. It is to decide by what means and in what circumstances the deceased met his death" (emphasis added).

See also HHJ Lucraft QC's ruling on Article 2 and determinations in the *Inquests arising from the deaths in the London Bridge and Borough Market terror attack* (2 August 2019) at ¶56

(d) An analogue to this point was considered in the s. 10(2) context in *R (GS) v Wiltshire and Swindon Senior Coroner* [2020] 1 WLR 4889 in relation to the Dawn Sturgess inquest following the Salisbury poisonings. In paragraphs 80-81 of his ruling on Article 2 ECHR and scope, the Senior Coroner had declined to consider whether Russian state agents were responsible for the death in part because doing so could lead to a finding that "*potentially could amount to a violation of*" Article 2 ECHR (by Russia). In addressing this point, the Court's discussion at ¶79-84 endorsed the directions of Sir John Goldring in the Hillsborough inquest, which was "*plainly correct as a statement of what section 10(2) does and does not prohibit*":

> "(f) You should not say anything to the effect that a crime or a breach of civil law duty of any kind has been committed. Note that this rule does not affect your answer to question 6 [whether those who died in the disaster were unlawfully killed]. Because of this rule, when writing any explanations, you should avoid using words and phrases such as 'crime/criminal', 'illegal/unlawful', 'negligence/negligent', 'breach of duty', 'duty of care', 'careless', 'reckless', 'liability', 'guilt/guilty'.
>
> (g) However, you may use ordinary and non-technical words which express factual judgments. So, you may say that errors or mistakes were made and you may use words such as 'failure', 'inappropriate', 'inadequate', 'unsuitable', 'unsatisfactory', 'insufficient', 'omit/omission', 'unacceptable' or 'lacking'. Equally, you may indicate in

> your answer if you consider that particular errors or mistakes were not made. You may add adjectives, such as 'serious' or 'important', to indicate the strength of your findings" (emphasis added).

In concluding that the Senior Coroner had erred in law in declining to investigate who was responsible for Ms Sturgess' death, the Divisional Court noted at ¶83 that, to avoid infringing s. 10(2)(b): "*No doubt in his determination he would be careful, as Sir John Goldring advised the Hillsborough jury to be, to avoid using inappropriate legal terminology*".

(e) Moreover, determining legal liability is a matter for Courts and judges, who possess the institutional competence to make such determinations: see *In the matter of an application by Steven Davis & ors for judicial review* [2017] NIQB 126 at ¶15. An inquiry panel may comprise those with judicial experience, but equally – as in this Inquiry – may not. Indeed, the Chair of this Inquiry was rightfully and appropriately appointed because of her experience in the detention field. She is thus well-placed to make factual findings and recommendations in relation to the ToR, but – respectfully – not to make determinations on legal liability. In *E7 v Chairman of the Azelle Rodney Inquiry* [2014] EWHC 452 (Admin) at ¶16, Irwin J pointed to s. 2 of the 2005 Act, before observing: "*The significance of any Report, however, is that it provides a public narrative which undeniably impacts not only on the position of those involved in the relevant incident or event but, additionally, on wider public interest issues*". Indeed, it was the approached recognised by the Historical Institutional Abuse Inquiry in Northern Ireland, which reported in 2017. By reference to the parallel provision (s. 1(5)) of the Inquiry into Historical Institutional Abuse Act (Northern Ireland) 2013, the panel reported in Chapter 1, paragraph 40:

> "The Inquiry was not a court and was expressly precluded by Section 1 (5) of the 2013 Act from (a) ruling upon, or (b) determining, any person's civil or criminal liability. This meant the Inquiry could not make a finding that rendered an individual or an institution guilty of a criminal offence, or subject to civil liability. That is the responsibility of the civil and criminal courts. However, this does not mean that the Inquiry could not identify acts or omissions which, if the same evidence were given in civil or criminal proceedings, might result in the award of damages or some other remedy, or a conviction…"

(f) That reaching conclusions of this nature is outwith the Inquiry's competence is also clear from the Explanatory Notes to the 2005 Act, which state in relation to s. 2:

> "The purpose of this section is to make clear that inquiries under this Act have no power to determine civil or criminal liability and must not purport

> to do so. There is often a strong feeling, particularly following high profile, controversial events, that an inquiry should determine who is to blame for what has occurred. However, inquiries are not courts and their findings cannot and do not have legal effect. The aim of inquiries is to help to restore public confidence in systems or services by investigating the facts and making recommendations to prevent recurrence, not to establish liability or to punish anyone."

(g) How the square is to be circled – i.e. making relevant factual findings, without treading impermissibly into the territory of determining civil liability - is a task that was helpfully described (in the context of an Article 2 inquest) by Lord Bingham in *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 at ¶37:

> "However the jury's factual conclusion is conveyed, rule 42 should not be infringed. Thus there must be no finding of criminal liability on the part of a named person. Nor must the verdict appear to determine any question of civil liability. Acts or omissions may be recorded, but expressions suggestive of civil liability, in particular "neglect" or "carelessness" and related expressions, should be avoided. Self-neglect and neglect should continue to be treated as terms of art. A verdict such as that suggested in para 45 below ("The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so") embodies a judgmental conclusion of a factual nature, directly relating to the circumstances of the death. It does not identify any individual nor does it address any issue of criminal or civil liability."

(h) Indeed, this approach is consistent with the judgment in *MA, BB*, in which there was recognition by the Secretary of State that there was a *prima facie* engagement of the procedural obligation to investigate under Article 3. Simply because the procedural limb of Article 3 is engaged, does not mean that the Inquiry is required to make findings as to whether there have been substantive breaches of Article 3:

(i) First, that is not a requirement of the procedural limb of Article 3, itself – which requires that the investigation be capable of establishing the facts of the case and identifying those responsible and is not an obligation of result, but of means (see, e.g., *Kaya v Turkey* (1999) 28 EHRR 1).

(ii) Secondly, to the extent that the procedural limb of Article 3 requires the UK to have in place a mechanism to determine whether or not there have been substantive breaches of Article 3, that is provided for by section 7 of the Human Rights Act 1998 – in circumstances in which s. 2(1) of the 2005 Act prohibits the Inquiry from doing so. Indeed, to the extent that the procedural limb of Article 3 also entails a requirement that an investigation be capable of leading to

the punishment of those responsible, there is no suggestion – nor could there be – that that element of Article 3 falls within the purview of the Inquiry.

196. For those reasons, G4S submits that the Inquiry is prohibited from making substantive findings that any party has breached Article 3 ECHR or that any person has been subject to treatment in breach of Article 3 ECHR – or words to the equivalent effect that constitute, in substance, such a finding (e.g. that a person suffered inhuman or degrading treatment – as these are legal terms of art within the rubric of Article 3). Therefore, G4S respectfully disagrees with the suggestions in CTI's 'Note to Core Participants Regarding the Approach to Findings of Fact under Article 3 ECHR' ("**CTI's Note**"), generally and in particular at paragraphs 5-6, 8 and 18(e), that it is open to the Chair to make findings of "*Article 3 violations*" or "*failures under Article 3*". Putting aside the question of whether such findings are open to the Chair in principle, G4S agrees that no finding of Article 3 breach should be made in respect of policies or practices – absent identified mistreatment or abuse directly caused as a result. It is trite to observe that a particular policy or practice can impact different detained persons in different ways; where it may contribute to an Article 3 violation in respect of one detained person; it may not in relation to an another. It is not the policy or practice, itself, which – in general – violates Article 3.

197. Indeed, CTI's note proposes that the Chair adopt the "*variable and flexible approach to the standard of proof*" that was applied in both the Undercover Policing Inquiry and the Baha Mouse Inquiry. It is precisely the statutory prohibition on making findings that amount to determinations of civil or criminal liability which underpins the conclusions of Sir Christopher Pitchford and Sir William Gage that they were able to adopt that approach in the context of public inquiries. As Sir William Gage put it in paragraph 20 of his ruling on the standard of proof:[263]

> "I recognise that in relation to some issues in this Inquiry, the more serious the allegation the more cogent must be the evidence to support a finding of wrongdoing. I must as a matter of fairness bear in mind the consequences of an adverse finding to any individual against whom serious allegations are made. However, by section 2 of the 2005 Act, I have no power to determine criminal liability, and the mere fact that criminal culpability might be inferred from my findings, does not in my judgment mean that I must adopt the criminal standard in making findings of fact. On the contrary, I think that the usual starting point will be to apply the civil standard but taking account of the "inherent improbability" concept where it properly applies" (emphasis added)

[263] https://webarchive.nationalarchives.gov.uk/ukgwa/20120215203943mp_/http://www.bahamousainquiry.org/linkedfiles/baha_mousa/key_documents/rulings/standardofproofruling7may2010.pdf

198. Indeed, that was also the approach taken by the panel of the Bloody Sunday Inquiry. In their ruling on the standard of proof, they said this at paragraph 18:[264]

> "As we have said earlier, since we are an Inquiry and not a Court (criminal or civil) we cannot give a verdict or pass a judgment on the question whether an individual was guilty of a specific crime or legally recognised serious wrongdoing. For the same reason the terminology and requirements of the criminal or civil law are largely inapplicable. Thus it seems to us that we can and should reach conclusions without being bound by rules designed for court cases, such as who has the burden of proof and the strict rules of evidence."

199. It is thus precisely *because* the Inquiry cannot "*pass a judgment on the question of whether an individual was guilty of… legally recognised serious wrongdoing*" that "*for the same reason the terminology and requirements of the criminal or civil law are largely inapplicable*" – including the burden and standard of proof.

200. Accordingly, G4S submits that it is only because the Inquiry is prohibited by statute from making findings that amount to determination of persons' rights and obligations, that it is lawful for it to adopt a 'variable and flexible' approach to the standard of proof. Thus, if the Inquiry accepts G4S' submissions in relation to the limits on the nature of the findings it can make (i.e. only findings of fact, not conclusions of law – in substance as well as form); then its proposed approach is lawful. If, however, the Inquiry proposes to make what amount to Article 3 findings (which G4S submits it cannot lawfully do), then the 'variable and flexible' approach is inapposite, and the Inquiry will be required to adopt the Article 3 standard of 'beyond a reasonable doubt' (as explained below). That stands to reason: by the same token, Article 6 is unlikely to be engaged by the conduct of the Inquiry – and G4S does not accept (if it is suggested) that the Inquiry has been conducted in an Article 6-compliant fashion – precisely because s. 2(1) of the 2005 Act means that the Inquiry does not engage any person's 'civil rights and obligations'. However, once the Inquiry trespasses beyond s. 2(1) and in practice makes such determinations, that would bring into play both Article 6 considerations of the Inquiry's conduct, as well as the standard of proof expected under Article 3.

201. In the premises, where G4S makes submissions below on the various incidents highlighted by the Inquiry as subject to its investigation and does so by reference to Article 3 threshold – those submissions are without prejudice to G4S' overarching submission that it would be

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[264] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279160/0029_x.pdf

ultra vires the 2005 Act for the Inquiry to make (or purport to make) findings as to whether conduct was in breach of Article 3, for the reasons set out above.

202. Were the Chair to take the view that she would be entitled to make findings which G4S submits above are impermissible to her, G4S submits that the Chair ought to make a preliminary determination in relation to the matter to enable any legal challenges to occur before her final report is drafted and published: a course of action to the contrary would risk the significant expenditure of Inquiry resource which could potentially be wasted if, for example, the approach taken were found to be unlawful. Similarly, it would unfair on any person (natural or legal) to potentially be named in a public report as having committed an Article 3 breach if, for example, it was not ever legally open to the Chair to make such a finding. Even a quashing order in respect of some or all of the final report would not unwind the professional and personal harms at stake.

203. G4S recognises that the Inquiry has been established within the rubric of Article 3 and that its ToR address 'mistreatment' by reference to it. As a result, while – for the reasons explained above – the Inquiry is prohibited from reaching conclusions as to whether there have been any breaches of Article 3, an understanding of Article 3 and will inform the Inquiry's approach to the factual matters that it is to address. As such, these submissions are therefore intended to assist the Inquiry in relation to the principles underpinning Article 3, as well as to set out the scope and boundaries of Article 3. They will address:

    (a) general principles applying to Article 3;

    (b) considerations as to what constitutes 'inhuman' and 'degrading' treatment;

    (c) the application of Article 3 in the context of detention;

    (d) the application of Article 3 in the context of healthcare; and

    (e) the positive obligations under Article 3

Article 3: general principles

204. Article 3 provides that: "*No one shall be subjected to torture or to inhuman or degrading treatment or punishment*". As will be well-known to the Inquiry, Article 3 is one of the absolute rights within the Convention, as opposed to a 'qualified' right (such as the right to freedom of expression under Article 10), in relation to which interferences may be lawful, if justified and proportionate. Similarly, states cannot derogate from Article 3 pursuant to

Article 15 of the ECHR. It is precisely because once treatment engages Article 3 it cannot lawfully be justified, that the threshold to engage Article 3 is, itself, a high one.

205. Article 3 is primarily focused on its negative obligations, i.e. states not subjecting individuals to conduct that meets the Article 3 threshold for mistreatment. However, it is accepted that Article 3 also consists of certain positive obligations, requiring contracting states to take certain positive steps to prevent individual suffering 'Article 3 mistreatment' in the hands of others (e.g. in the context of extraditions to jurisdictions where punishment could be inhuman or degrading). That obligation has been described in *Z v United Kingdom* (2002) 34 EHRR 3 at ¶C94 as one: "*to take those steps that could be reasonably expected of them to avoid a real and immediate risk of ill-treatment contrary to Article 3 of which they knew or ought to have had knowledge*".

206. By its own terms, to meet the test for Article 3, the relevant treatment or punishment must amount to torture, or be "*inhuman or degrading*". There is a distinction between treatment which is inhuman or degrading, and that which amounts to torture. As the European Court of Human Rights ("**ECtHR**") held in *Ireland v United Kingdom* (1979-1980) 2 EHRR 25 at ¶167, that distinction "*derives principally from a difference in the intensity of the suffering inflicted*". Specifically, by 'torture', the Convention: "*attach[es] a special stigma to deliberate inhuman treatment causing very serious and cruel suffering*".

207. 'Torture' is thus the most intense form of suffering covered by Article 3. The Inquiry will note that in the *Ireland* case, notwithstanding the nature of the techniques in issue (wall-standing, hooding, subjection to noise and deprivation of sleep, food and drink), these did not constitute 'torture' because the level of suffering caused was not sufficiently intense or cruel. The type of treatment that does meet this threshold is, for example, that in *Akkoc v Turkey* (2002) 34 EHRR 51 at ¶116: electric shocks, hot-and-cold water treatment, blows to the head, and threats concerning the ill-treatment of her children, leaving the victim with post-traumatic stress disorder requiring treatment by medication.

208. 'Inhuman' treatment is similarly more egregious than that which is 'degrading' (such that all inhuman treatment will also be degrading, but not necessarily vice versa). As the European Commission on Human Rights put it in *The First Greek Case* (1969) 12 Y.B. 1 (cited in *East African Asians v United Kingdom* (1981) 3 EHRR 76 at ¶249):

> "It is plain that there may be treatment to which all these descriptions apply, for all torture must be inhuman and degrading treatment, and inhuman treatment also degrading. The notion of inhuman treatment covers at least such treatment as deliberately causes severe suffering, mental or physical, which in the particular situation is unjustifiable. …

> Treatment or punishment of an individual may be said to be degrading if it grossly humiliates him before others or drives him to act against his will or conscience."

209. Even to amount to inhuman or degrading treatment, so as to fall within the scope of Article 3, the ill-treatment "*must attain a minimum level of severity*" (*Ireland v United Kingdom*, ¶162); that standard is relative: "*it depends on all the circumstances of the case such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim, etc.*" In *R (Limbuela) v Secretary of State for the Home Department* [2006] 1 AC 396, Lord Bingham at ¶7 observed, in line with position, that: "*the treatment, to be proscribed, must achieve a minimum standard of severity, and I would accept that in a context such as this, not involving the deliberate infliction of pain or suffering, the threshold is a high one*".

210. Indeed, that notion of the 'high' bar is echoed elsewhere in the caselaw: see, e.g., *R (MD) v Secretary of State for the Home Department* [2014] EWHC 2249 (Admin) at ¶139 ("*I am conscious of the high threshold set for a successful claim under Article 3*"). Further, as the Court of Appeal put it in *R (ASK) v Secretary of State for the Home Department* [2019] EWCA Civ 1239 at ¶69:

> "A high level of suffering is usually required, variously put in terms of (e.g.) "…intense suffering …" (*Iovchev v Bulgaria* (2006) (ECtHR Application No 41211/98) [2006] ECHR 97 at [133]); "… serious suffering…" (*R (Limbuela) v Secretary of State for the Home Department* [2005] UKHL 66 at [8] per Lord Bingham), or "… intense physical or mental suffering" (*Pretty* at [52])."

211. The Court went on at ¶70 to draw from the Strasbourg jurisprudence that: "*ill-treatment that attains the appropriate minimum level of severity usually involves the relevant individual suffering evidenced actual bodily harm or intense physical or mental suffering*".

212. It should be noted, that the ECHR recognises the often-inevitable consequences – even psychological – of certain legitimate forms of treatment or punishment. Those consequences, even if adverse, do not render the treatment as in breach of Article 3. As the ECtHR put it in *Kudla v Poland* (App. 30210/96) at ¶92: "*the Court has consistently stressed that the suffering and humiliation involved must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment*". Further, the Court has accepted that there will be a: "usual degree of intimidation and humiliation that is inherent in every arrest or detention": *Ozkan v Turkey* (App. 21689/93) at ¶343.

213. The standard of proof applicable to Article 3 violations is that set out in *Ireland v UK* at ¶161, which is 'beyond reasonable doubt', although the ECtHR did point out as a gloss that: "*such proof may follow from the coexistence of sufficiently strong, clear and concordant inferences or of similar unrebutted presumptions of fact*". That standard applies to the factual question of what took place: *R (VC) v SSHD* [2018] EWCA Civ 57 at ¶125.

Torture

214. It is to be noted that in the Chair's Opening Statement, she observed that: "*this Inquiry will examine whether the treatment experienced in Brook House was contrary to Article 3 of the European Convention on Human Rights and therefore amounted to inhuman or degrading treatment or punishment*". With her reference to both inhuman and degrading treatment, but not to torture, it appears that the Chair (provisionally) did not consider the Panorama footage to disclose evidence of torture. She was right to take that view. However, it is noted that D1527 has invited the Inquiry to conclude that the incident involving himself and Yan Paschali on 25 April 2017 "*constituted not just inhuman and degrading treatment, but torture*". G4S will invite the Inquiry in due course not to take up that invitation, but it will require the Inquiry to appreciate what the case law demands before a torture finding can be made.

215. Torture is distinguished from the other forms of Article 3 mistreatment primarily by the intensity of suffering inflicted: *Ireland* at ¶167. Indeed, as noted above, in the *Ireland* case the techniques of wall-standing, hooding, subjection to noise and deprivation of sleep, food and drink were not serious enough to constitute torture. The ECtHR in *Selmouni v France* (2000) 29 EHRR 403 relied upon the definition of torture providing in Article 1 of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which provides that:

> "… 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with consent or acquiescence of a public official or other person acting in an official capacity…"

216. Key, therefore, to the infliction of torture is not only the severity of the pain or suffering caused, but also both the intentional nature of the harm, as well as it being inflicted for particular purposes: to extract information or a confession, as punishment, or based on discrimination. Indeed, in *Denizici v Cyrpus* (App. No. 25316/94, 23 May 2001) the ECtHR found that the beating of detainees did not meet the definition of 'torture', because it had not been demonstrated to have been done for the purposes of obtaining confessions; neither are poor prison conditions: *Peers v Greece* (2001) 33 EHRR 51.

217. CTI is right to point out that:[265]

> "a very high degree of [physical][266] suffering and often humiliation intentionally inflicted…is needed to reach the minimum level of suffering that qualifies as torture for the purposes of Article 3. An episode of relatively short duration would not likely reach the necessary level of suffering and humiliation to qualify as torture"

218. As noted above, it is extreme brutality such as electric shocks in *Akkoc* which have been held to meet the definition on 'torture'. That is because, as the Strasbourg Court observed in the *Ireland* case, the purpose of a distinct concept of 'torture' is to attach a "*special stigma to deliberate inhuman treatment causing very serious and cruel suffering*". In appreciating the ECtHR's decision in the Ireland case - that the relevant techniques did not amount to torture – it is important to recognise also that the Commission had observed that they had caused some physical pain, but which stopped when the treatment ceased; as well as certain acute psychiatric conditions, which it could not be excluded continued for some time afterwards. Other types of conduct which meet the threshold for torture include rape – "*inherently debasing*" (*Aydin v Turkey* (25 September 1997) at ¶189; *Maslova and Nalbandov v Russia* (24 January 2008) at ¶105).

219. Perhaps more pertinently, in *Egmez v Cyprus* (21 December 2000), where ill-treatment was meted out over a short period of time and there was some doubt as to the gravity of injuries, the ECtHR was unwilling to conclude that the mistreatment met the definition of 'torture'. By contrast, in *Selmouni*, where a finding of torture was made by the Court, the assaulting and humiliation of the applicant took place over a number of days.

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[265] CTI's Note, paragraph 21

[266] G4S accepts the submission that mental suffering *could* potentially meet the test, but the threshold – whether the suffering is mental or physical – remains particularly high.

'Inhuman' and 'degrading' treatment

220. As set out above, the terms 'inhuman' and 'degrading' have specific meanings and particular thresholds in Article 3 jurisprudence. *Tyrer v United Kingdom* (1979-80) 2 EHRR 1 was a case that concerned the judicial corporal punishment of 'birching', in which the applicant was required to take down his trousers and underpants, bend over a table and was given three strokes of the birch in the presence of his father and a doctor. The Court concluded at ¶29 that this did not amount to 'inhuman' treatment:[267]

> "Nevertheless, it remains true that the suffering occasioned must attain a particular level before a punishment can be classified as 'inhuman' within the meaning of Article 3. Here again, the Court does not consider on the facts of the case that that level was attained and it therefore concurs with the Commission that the penalty imposed on Mr. Tyrer was not 'inhuman punishment' within the meaning of Article 3".

221. In considering whether treatment is 'degrading', "*the Court will have regard to whether its object is to humiliate and debase the person concerned and whether, as far as the consequences are concerned, it adversely affected his or her personality in a manner incompatible with Article 3*" (*Raninen v Finland* (1997) 26 EHRR 563 at ¶55, emphasis added).[268] In that regard, the public nature of the punishment or treatment may be a relevant factor (but the absence of publicity will not necessarily prevent a given treatment from falling into that category). As can be seen in the excerpt from *The First Greek Case* above, degrading treatment is that which "*grossly humiliates*" an individual "*before others*" or "*drives him to act against his will or conscience*".

222. It is possible for treatment to be both inhuman and degrading. That was the case in *Ireland v United Kingdom* in relation to the 'five techniques', the application of which was 'inhuman' because they were applied "*in combination, with premeditation and for hours at a stretch*" and caused "*if not actual bodily injury, at least intense physical and mental suffering... and also led to acute psychiatric disturbances*"; but at the same time 'degrading' since they were such "*to arouse in their victims feelings of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance*" (¶167).

223. The impact of conduct on the physical or mental health of the person receiving it may also be a relevant consideration as to whether that conduct contravenes Article 3. Again,

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[267] But did constitute 'degrading' treatment: ¶33.

[268] See also *Albert and Le Compte v Belgium* (1983) 5 EHRR 533 at ¶22.

however, for Article 3 to be engaged significant on the basis of its result (rather than simply its nature by definition), its impact must be substantial. In *O'Rourke v United Kingdom* (App. 39022/97), the fact that the applicant had remained on the streets for 14 months, "*to the detriment of his health*", including a deterioration of his asthma did not meet "*the requisite level of severity to engage Article 3*". Similarly, in *Bilgin v Turkey* (2003) 36 EHRR 50 at ¶103, it was the destruction of the applicant's home and possessions which led the Court to conclude that this must have caused "*suffering of sufficient severity for the acts of the security forces to be categorised as inhuman treatment*".

Article 3 ECHR and detention

224. As starting point, when detention is protective, without more it will not constitute 'punishment' within the meaning of Article 3: *DG v Ireland* (2002) 35 EHRR 33 at ¶96.

225. Furthermore, the Courts have upheld as not breaching Article 3, various methods of restraint, so long as used lawfully and for a legitimate purpose. These have included:

    (a) Handcuffing an individual to a radiator for three hours: *M-AV v France* (App. 21788/93);

    (b) Handcuffing and blindfolding (as well as sedation, although that allegation was not substantiated): *Ocalan v Turkey* (2003) 37 EHRR 10 at ¶215-228;

    (c) Handcuffing on the way to hospital (*Raninen* at ¶58) and during hospital appointments (*R (Spinks) v Secretary of State for the Home Department* [2005] EWCA Civ 275 at ¶39-47.

226. As explained above, the Court is mindful of the fact that detention is, by its nature, a potentially challenging time for those subject to it, and carries with it a certain amount of inherent humiliation. That will not, in and of itself, constitute a breach of Article 3. It is not even enough for conditions in a detention facility to have a "*depressing and discouraging effect*": *Hilton v United Kingdom* (1981) 3 EHRR 104 at ¶97. In *Hilton*, the Commission pointed to the: "*the conditions of over-crowding and understaffing… and the rigorous, impersonal application of disciplinary measures, on occasions to the point of absurdity (for example, the applicant's punishment for putting his hands in his pockets)*". That was not, however, enough to meet the bar set by Article 3 for degrading treatment. Similarly, in *Szafranski v Poland* (2017) 64 EHRR 23, the ECtHR found that insufficient

heating/ventilation, leading to intense heat levels and minimal partitions between cells and toilet facilities did not contravene Article 3.

227. Moreover, in *R (NB) v Secretary of State for the Home Department* [2021] 4 WLR 92, Linden J pointed out at ¶262 that:

> "It is superficially attractive to move from my conclusion that during the relevant period the Barracks did not "ensure a standard of living adequate for the health of the applicants", and/or could not rationally be viewed as adequate for their needs, to the conclusion that therefore accommodating the claimants at the Barracks amounted to inhuman and degrading treatment of them. But Mr Hickman rightly accepted that the latter does not follow from the former: the threshold which the claimants have to cross under article 3 is a higher one" (emphasis added).

228. In that regard, it is appropriate to consider, in objective terms, the nature of the conduct under consideration, rather than, necessarily, what occurred as a result. For example, in *Bollan v United Kingdom* (2000) 30 EHRR CD343, a short period of confinement in a detainee's own cell "*did not reach the minimum level of severity required by Article 3 of the Convention to disclose either inhuman or degrading treatment or punishment*". That was not changed by the fact that the confinement in fact led to the detainee's suicide, given that "*there were no indications, physical or mental, which rendered, or should have rendered, the prison authorities aware that Angela Bollan was at risk of any acute or severe suffering as a result of the measure*" (see also *ASK* at ¶71).

229. Furthermore, the jurisprudence is clear that removing a detainee from the community does not, itself, constitute inhuman or degrading treatment, when carried out for "*security, disciplinary or protective reasons*"; a situation to be contrasted with "*complete sensory isolation, coupled with total social isolation, [which] can destroy the personality and constitutes a form of inhuman treatment*": *McFeeley v United Kingdom* (1981) 3 EHRR 161. Where the level of risk justifies it, the extent of confinement permitted by Article 3 can be substantial: in *M v United Kingdom* (App. 9907/82), for example, although an extreme case, there was no contravention in circumstances in which the applicant was detained in a 2x4m cage-like cell for 23 hours each day, and he was not permitted to see or speak to any other prisoner. On the other end of the spectrum, there is neither a prohibition on the mixing of convicted detainees with those who do not have convictions: *X v Belgium* (App. 6337/73).

230. In immigration detention contexts in particular it has taken extreme conditions for the ECtHR to find that Article 3 has been breached: no possibility of exercise, lack of basic

amenities (such as bedding, hygiene and telephone access to the outside world) – *SD v Greece* (11 June 2009) at ¶51-54.

Article 3 ECHR and healthcare

231. In line with the recognition in the jurisprudence that detention may be an inherently dispiriting experience, the case law similarly recognises that some detainees, by virtue of a psychological or mental health condition, may find the experience of detention more difficult than others. As in respect of the general feelings of distress surrounding detention, so too there will not be a breach of Article 3, simply because a detainee is more vulnerable because of a psychological condition, or even where "*his detention may have exacerbated to a certain extent his feelings of distress, anguish and fear*": *Kudla v Poland* (2002) 35 EHRR 11 at ¶99.

232. In the context of detention, the ECtHR has recognised that Article 3 contains an obligation to protect the health of persons deprived of liberty: *Keenan v United Kingdom* (2001) 33 EHRR 38 at ¶110. In *Keenan* the ECtHR did suggest that the lack of appropriate medical treatment may amount to a contravention of Article 3. It cited *Ilhan v Turkey* (2002) 34 EHRR 36 at ¶87 as authority for that proposition; consideration of *Ilhan* shows the extremely high bar for such a finding – in that case the Court's conclusion that Article 3 had been breached was not simply on the basis of a failure to provide timely medical attention. It was "*the severity of the ill-treatment suffered… and the surrounding circumstances, including the significant lapse in time before he received proper medical attention*". Notably the ill-treatment suffered, which was the foundation for the finding of Article 3 being contravened, included being kicked, beaten and struck with a rifle, causing brain damage. Indeed, a delay of 14 days (until release) in providing appropriate TB treatment did not breach Article 3 (*Gavrilita v Romania* (22 June 2010) at ¶ 34-35); not did delays in providing medication to a hepatitis C sufferer, where overall treatment was continued to be provided and there was no deterioration in condition (*Micu v Romania* (5 January 2016) at ¶57-62).

233. In respect of healthcare provision, generally, so long as the detention facility is either able to provide suitable medical care, itself, or transfer detainees to hospital for treatment when necessary, Article 3 will not be engaged: *Chartier v Italy* (1984) 6 EHRR CD387 at ¶49ff; *De Varga-Hirsch v France* (App. 9559/81). Indeed, it is trite but worth pointing out that "*Article 3 does not generally require the release of a detainee, or his transfer to hospital, on health grounds*": *ASK* at ¶118(ii). Furthermore, the Strasbourg Court has not adopted a standard expecting healthcare facilities in detention to match those in the outside world.

Rather, the standard of care is more flexible, and recognises the detention context: *Alexsanyan v Russia* (22 December 2008) at ¶139-140.

234. Merely being taken to a hospitable for a potentially intimate gynaecological examination (but where the examination was not in fact performed) does not attain the minimum level of severity to constitute an Article 3 breach, even if it caused distress: *Turan v Turkey* (App. 879/02) at ¶18-21. Similarly, neither does a failure to provide a detainee with pain-killing medication, even on several occasions: *Rehbock v Slovenia* (App. 29462/95) at ¶80.

235. It is also appropriate to point out that where a detainee refuses medical assistance, Article 3 does not hold the detaining authorities responsible for any consequent harm suffered: *McQuiston v United Kingdom* (App. 11208/84)

Positive obligations under Article 3 ECHR

236. Article 3 requires certain positive action by states to ensure that individuals within their jurisdiction are not subjected to torture or inhuman or degrading treatment. Typically that 'positive' obligation arises in the context of refraining from extraditing or deporting an individual to a foreign state where they are likely to receive treatment that would contravene Article 3.

237. That obligation does not, however, extend to an absolute requirement on states to prevent all forms of inhuman and degrading treatment that occur within their jurisdiction. That would be too high a bar; and a standard neither reachable nor fair to hold states to. Instead, the obligation is limited to a requirement to: "*take those steps that could reasonably be expected of them to avoid a real and immediate risk of ill-treatment contrary to Article 3 of which they knew or ought to have had knowledge*" (*Z*, cited above; see also *DP and JC v United Kingdom* (2003) 36 EHRR 14 at ¶109-114).

238. It is right to say that the positive obligations under Article 3 apply in respect of "*children and other vulnerable persons*" (*Z v United Kingdom* (2002) 34 EHRR 3 at ¶73). However, where a particular vulnerability is in issue in terms of the impact it should have on the steps taken by the state to avoid that person suffering mistreatment, there must be an obvious causal link between the relevant vulnerability, and the likelihood that the person would suffer mistreatment. In *Gezer v Secretary of State for the Home Department* [2004] EWCA Civ 1730 the appellant suffered from mental health difficulties. On any view, that would render him a 'vulnerable' person. However, the relevant abuse suffered was racial in nature, and

the Court of Appeal found that the appellant's mental health status did not mean that additional steps were required by the state to obviate the risk of racial harassment. It observed at ¶58 that:

> "As NASS had been told, the appellant was suffering from mental illness. This, said Mr Rabinder Singh Q.C. for the appellant, made him and his family particularly vulnerable to the effects of the unlawful treatment by third parties. Yet, he submits, there was no evidence that NASS had even taken account of this particular factor at all. It ought to have considered his specific difficulties when assessing what constituted reasonable steps to protect his Article 3 rights. I do not accept that submission. The appellant's illness clearly did not affect the risk of attack or harassment. At best it could be material to the gravity of the injury suffered from any such conduct, but even that is not plain from the medical evidence. This may be because the argument barely surfaced before the judge, which no doubt explains why he did not expressly deal with it in his careful judgment. In any event, I agree with Laws LJ that there was nothing sufficiently exceptional in the position of this appellant which ought to have caused NASS to conclude that he merited consideration as an exception to the general policy" (emphases added).

239. It is important to note, though, as was observed in *Gezer* at ¶55, that:

> "Sufficiency of protection is not, however, a guarantee that no treatment of the level of severity sufficient to engage Article 3 will occur. Consequently, contrary to the submissions of the appellant, the fact that the treatment did, as the judge found, reach that level of severity does not prove that the protection was inadequate and thereby infringed Article 3. What is required is that there must be an ability and willingness to provide an effective system of protection, having regard to the practical realities: see the observations of Lords Hope and Clyde in *Horvath v Secretary of State for the Home Department* [2001] AC 489 pp.500 and 510 respectively."

The Shaw Review

240. Stephen Shaw's 2016 *Review into the Welfare in Detention of Vulnerable Persons* contains at Appendix 4 an 'Article 3 sub-review' prepared by Jeremy Johnson QC (as he then was) an 'assessment of cases where a breach of Article 3 [ECHR] has been found in respect of vulnerable immigration detainees'. In Appendix 4, Jeremy Johnson QC identified 6 cases in which a breach of Article 3 had been found, as well as an additional number in which there was no concluded breach of Article 3.

241. It is appropriate to identify the key themes that emerge for these cases – not in terms of factual findings made by the Courts (as these occurred before the Relevant Period and across

various IRCs, thereby being outside the Inquiry's ToR), but to understand the approach taken by the domestic court to the Article 3 threshold in the immigration detention context.

242. In R (S) v SSHD [2011] EWHC 2120 (Admin), the Court found the treatment of the Claimant to amount to a breach of Article 3. Relevant to that conclusion was the Court's conclusion that the detention of S was unlawful from the outset and the fact that there was clear expert advice before and during detention that it was liable to cause serious mental health problems: ¶213. There was a clear failure to follow or apply express medical advice that "*detention itself was the problem*": ¶214 and thus the detention involved debasement and humiliation since it disclosed a serious lack of respect of S' human dignity and created in his mind a real state of anguish and fear: ¶212.

243. R (BA) v SSJDH [2011] EWHC 2748 (Admin) was a case in which there was a breach of Article 3 reflected in the "*deplorable failure*" to recognise the nature and extent of the claimant's illness. Although he was detained from 1 February 2011 and first showed signs of disturbance on 30 March 2011, the Court found that the Article 3 threshold was not in fact met until 4 July 2011, when the interim healthcare manager at the IRC reported that the claimant was "*in such poor physical condition that he should now be considered unfit to be detained*" The Court's approach was realistic – and recognised the fact that even if the claimant's food refusal was caused by his illness, "*it is extremely difficult to deal with such behaviour in a way which both respects personal dignity and autonomy, and also safeguards health*". It also took into consideration the fact that nobody charged with his care "*deliberately set out to cause him suffering or distress*": ¶237. When reaching a finding of a breach of Article 3, however, the Court did specifically rely upon (on one occasion) "*a callous indifferent to [the claimant's] plight*".

244. In R (HA) Nigeria v SSHD [2012] EWHC 979 (Admin) the Court accepted the claimant's submission that his treatment was in breach of Article 3 – in particular based on a combination of factors that linked his serious mental illness with the repeated use of force against him; the failure to provide him with appropriate medical treatment for over 5 months; his segregation from others; and acts which violated his dignity, including sleeping on the floor (often naked) in a toilet area, drinking and washing from the toilet, and not washing or changing his clothes for potentially over a year.

245. In R (D) v SSHD [2021] EWHC 2501 (Admin) the Court found that the absence of provision of proper psychiatric treatment for the claimant over many months, exacerbating mental suffering ultimately amounted to a breach of Article 3, where: (a) it was 'premeditated', in

the sense that those responsible for his wellbeing were aware of his history of mental illness and "*persisted in a medical regime for him which involved neglect*" (including denial of access to a psychiatrist) and also recourse to rule 40 and 42 which were not suitable for someone with the claimant's condition: ¶181. Furthermore, the Court found "*decisive*" the expert conclusion that the periods of immigration detention had been a "*main cause*" of the claimant's prolonged mental health difficulties (leading to a lack of legal capacity): ¶182.

246. However, while the Court did accept that the treatment (or lack of treatment) of the claimant amounted to a breach of Article 3 in respect of the period of his detention at Brook House and Harmondsworth, it did not find the same in relation to the period of his detention at Colnbrook. That was notwithstanding its findings that (¶184-185):

    (a) The claimant's lack of legal capacity continued throughout the period he was detained at Colnbrook;

    (b) The medical regime at Colnbrook was "*brusque and insensitive to the particular circumstances and mental state of D, and stubbornly resistant to external criticism*", including "*thwart[ing]*" the Treasury Solicitor's attempts to obtain its own psychiatric reports – which delayed the claimant's recovery and stymied the opportunity to transfer him to a psychiatric hospital.

    (c) The response to the claimant's dirty protests included segregation and did not take account of the link between his hallucinations and the dirty protests – which were symptomatic of his mental illness.

247. Ultimately, at Colnbrook the claimant did receive psychiatric reviews fortnightly and even though these written reviews were "*deficient*", the Court was satisfied that the claimant's treatment at Colnbrook was not "*inhuman*" and did not fall any longer below the minimum Article 3 threshold: ¶185.

248. Jeremy Johnson (rightly) did not give substantive consideration to the case of R (S) v SSHD [2014] EWHC 50 (Admin) because the High Court's judgment was overturned by the Court of Appeal: [2015] EWCA Civ 652: the claimant in that case also accepted that the judgment was deficient. The Court of Appeal's conclusion at ¶10 included that "*none of [the High Court's] findings of fact nor any of [its] conclusions of law will be of any significant, either to the future conduct of this case or indeed to that of any other*".

249. In R (MD) v SSHD [2014] EWHC 2249 (Admin) the Court found a breach of Article 3 where the medical expert evidence demonstrated that "*detention did not exacerbate a pre-existing*

mental disorder but caused the onset of the mental disorder that was subsequently manifest": ¶134-5, 139. This included "*episodes of acutely severe mental distress*" and self-harming six times over a five-week period. Against that backdrop, the various forms of restraint and removal from association increased the claimant's suffering and was found by the Court to be degrading "*because it was such as to arouse in the claimant feelings of fear, anguish and inferiority likely to humiliate and debase the claimant in showing a serious lack of respect for her human dignity*": ¶141. Indeed, the handcuffing of the claimant was viewed as *an unacceptable way of dealing with someone with mental illness except as a very short term measure while expert help is sought*": ¶137.

250. Jeremy Johnson QC also recognised that: "*there are large numbers of cases where the court has not found a breach of Article 3 but where it has found that detention was unlawful*". In some of those cases Article 3 was not argued, or was not subject to the Court's detailed consideration because it added little to other arguments. As such, these cases were dealt with briefly by Jeremy Johnson QC, but two points are worth noting:

    (a) In *R (Xue) v SSHD* [2015] EWHC 825, the Court at ¶108 referred to the judgment of the Court of Appeal in *IM (Nigeria) v SSHD* [2013] EWCA Civ 1561, to note that: "*the bar for a breach of article 3 in this context is high one, especially when some treatment has been made available but a detainee's acceptance of that treatment has been erratic...*"

    (b) In *R (EH) v SSHD* [2012] EWHC 2569 (Admin), the Court recognised that even though the claimant's detention was unlawful (in light of the SSHD's policy on the detention of the mentally ill), that did not mean it was necessarily also in breach of Article 3. "*In assessing whether the Defendant acted in breach of Article 3, it is important to consider carefully the medical evidence from those who were assessing his condition at the time*": ¶204. 'Decisive' to the Court's conclusion that Article 3 had not been breached was the standard of care provided to the claimant, including that: "*When he was believed to be at risk he was under constant observation. He had frequent and prompt access to nursing care when required*": ¶215.

Submissions on the incidents

251. G4S turns now to make submissions on the individual incidents which are the subject of the Inquiry's investigation. To assist the Inquiry, it does so by reference to the 'Schedule of Incidents' circulated by the Inquiry on 16 November 2021 ("**the SoI**"). G4S' understanding

is that this document, prepared by the Inquiry, identifies those particular 'incidents' on which the Inquiry is focusing. Indeed, the email under cover of which the SoI was sent stated that:

> "This is a living document that has been prepared by the Counsel to the Inquiry to assist Core Participants preparations for the Phase 1 and 2 hearings. It collates evidence relevant to a selection of incidents which the Inquiry intends to investigate during the Phase 1 and Phase 2 hearings.
>
> As this a 'living document', the version attached is not a definitive list of: the incidents that will be considered by the Inquiry; or documents relevant to each incident – as the Inquiry progresses over the coming months, and evidence is received / reviewed, the document will be updated and further iterations will be shared with Core Participants at appropriate stages."

252. When the SoI was first disseminated on 16 November 2021, the Inquiry intended to treat it as a 'living document' and to add to it any further incidents which it intended to investigate in light of further evidence received and/or reviewed. As no further iteration of the SoI has been shared with Core Participants, G4S accordingly understands that the Inquiry has not added to this list of incidents, which are the focus of its investigation.

253. These submissions address in turn each of the 53 'incidents' included within the SoI; for ease, they do so – as in the SoI – chronologically, using the 'row number' from the SoI itself (i.e. commencing with Row 2, the incident on 8 November 2016).

254. Before doing so, however, it is necessary to make some preliminary observations that apply generally to a number (or all) of the incidents, and the approach that the Inquiry should take to make findings in respect of them.

Row 2: Allegation that Derek Murphy punched D182 on 8 November 2016

255. This incident allegedly occurred in November 2016, over four months before the Relevant Period. As an incident in its own right, therefore, consideration of whether it constituted mistreatment against D182 is outside the Inquiry's ToR and thus no such findings should – or even lawfully could – be made by the Inquiry.

256. G4S does not suggest that the incident is wholly excluded from the Inquiry's consideration: the Inquiry can look outside the Relevant Period, for example, for points of comparison – but only where doing so furthers its consideration of incidents and matters during the Relevant Period. For that reason, the Inquiry cannot make mistreatment findings in respect of incidents that lie outside the temporal scope of the Relevant Period. Beyond the formality of the confines of the ToR, that is also a matter of fairness to Core Participants and other

relevant individuals or parties. Such parties, as well as witnesses, have prepared for hearings and given disclosure on the basis of the Inquiry's ToR – which includes its temporal scope. Were the Inquiry to make findings on the question of mistreatment in respect of incidents outside the Relevant Period it would do so: (a) without parties having fairly had the opportunity to prepare to deal with such matters; and (b) without the benefit of evidence (documentary and witness) in respect of the time period in which the relevant incident[s] occurred.

257. Furthermore, and perhaps because any alleged mistreatment that took place in November 2016 lay outside the Inquiry's ToR, Derek Murphy was not questioned about this alleged incident by CTI when he gave his oral evidence. In those circumstances – and echoing the submissions immediately above – the Inquiry could not fairly, nor lawfully, make findings in relation to this incident.

258. Without prejudice to that point, G4S merely notes that in the investigation report into Derek Murphy (which did find *other* allegations against him to be substantiated), in relation to what occurred in November 2016 the investigating officer observed:[269]

> "There is use of force paperwork dated 8th November 2016 Log No 126/16 which supports DCO Murphy's claim he had been bitten. CCTV footage shows DCO Murphy lifting his trouser leg to show a colleague where he had been bit. The paperwork refers to the detainee being aggressive throughout but does not demonstrate that DCO Murphy assaulted the detainee."

259. Furthermore, and for completeness, it would similarly be unfair for the Inquiry to make any positive findings in relation to the suggestion that (per cell B2 of the SoI): "*alleged that on an unknown date, Derek Murphy punched a detained person in the jaw after previously being bitten by him*". That is a serious allegation, in respect of which fairness demands that Core Participants and, in particular, Derek Murphy, be made aware: (a) whom Derek Murphy is said to have punched; and (b) when that punch is said to have occurred.

260. G4S notes that the source of that allegation appears to be a conversation between Daniel Small and Daniel Lake on 13 May 2017, as undercover-recorded by Callum Tulley.[270] However, evidence did not emerge in the course of the Inquiry (whether by witness statement or during its oral hearings) which provided any further particulars or details of this alleged incident, nor which substantiated it. In particular, Daniel Lake's evidence was that he could

[269] HOM005830_0010

[270] TRN0000095_0032

not recall the incident, and so may even have heard about it second-hand from another officer.[271] He stood by that evidence when questioned by CTI: "*I don't remember seeing it, no*".[272] In fact, his next response – suggesting that if he had seen a staff member upper-cut someone straight in the jaw he may well have remembered doing so;[273] points to Daniel Lake having not in fact witnessed any such incident.

261. As a result, when CTI questioned Derek Murphy on 2 March 2022, and put to him the following, that was an unfair characterisation of Daniel Lake's evidence and should not have put to Derek Murphy:[274]

> "In his evidence yesterday, I think it was, Dan Small talking of events on 13 May, said that he thought he'd been referring to you. He was asked about this by Mr Livingston on behalf of the inquiry. That he thought he'd been referring to you, but he couldn't remember the incident. But when he was pressed on it, he said that, effectively, what he was saying was accurate, or what was being said here was accurate, that he saw everything and that you had cracked this man in the jaw. It was Lake, forgive me, not Dan Small. Dan Lake was saying in his evidence that he thought he'd been referring to you, he couldn't particularly remember it, but that he said he saw everything and that you had upper-cutted this man and cracked him in the jaw. So we have evidence from another erstwhile colleague of yours who said, as far as he recalled it, it happened. He was telling the truth" (emphasis added).

262. That is simply not a fair characterisation of Daniel Lake's evidence; and the Inquiry has no real basis on which it should not accept Derek Murphy's evidence that he did not upper-cut a detained person;[275] - all the more so where there is no evidence as to exactly when this punch is said to have occurred; nor who was its victim, for Derek Murphy to be able to respond properly, or other Core Participants (including G4S) to undertake searches to look for evidence in relation to it.

Row 3: Use of force against D1234 on 28 March 2017

263. Again, as a preliminary point, this is also an incident that occurred outside the temporal scope of the Inquiry's ToR, having taken place in March 2017. For the reasons already

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[271] BDP000002_0016, para 49

[272] Daniel Lake 1 March 2022 49/15-23; 50/13-17

[273] Daniel Lake 1 March 2022 49/24-50/2

[274] Derek Murphy 2 March 2022 99/11-100/1

[275] Derek Murphy 2 March 2022 99/19-10

outlined above, it would be neither lawful nor fair for the Inquiry to make any findings of mistreatment in relation to it.

264. Without prejudice to those submissions, however, G4S provides its observations in relation to the incident on 28 March 2017 below, particularly as – notwithstanding it falling outside the Inquiry's temporal scope – it has been considered by Mr Collier.

265. It is appropriate to make some observations about the evidence available to the Inquiry in relation to this incident: not only witness evidence (including the live evidence of Mr Dix); various forms of documentary evidence (see the references given by Mr Collier), but also video footage of the incident, itself.[276] As such, there can be little doubt as to the facts of what occurred; rather, any issues concern the appropriateness of the approach demonstrated by the footage. It also has the benefit of a detailed, 38-page report by the PSU.[277] Moreover, the Inquiry has not heard live evidence from D1234, but instead his evidence was read-in.[278] As the read-in evidence explained, D1234 did not provide an account of his experiences to the Inquiry directly, but the Inquiry was reliant for his account on that included within his original complaint to the Home Office.[279] While, for example, Mr Dix's evidence could be tested under examination by CTI, D1234's could not. The Inquiry is invited, therefore, to treat his written account with some caution.[280] More than the fact that D1234's account could not be tested, it is in fact not supported (indeed flatly contradicted) in material respects by the video footage which Inquiry possesses.

266. G4S recognises the expertise of Jonathan Collier in respect of the use of force, and – save where Mr Collier has made an error – is unlikely to demur from his views within his field of expertise. To set this incident in context, therefore, it is important to recall Mr Collier's

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[276] Disk 23 S1940003.

[277] HOM002750.

[278] D1234 (read-in) 10 December 2021 171/11-175/20.

[279] Contrary to the read-in summary at D1234 (read-in) 10 December 2021 173/1-5, it appears to G4S that the statement which accompanied the letter from Harriet Harman QC MP to the Home Office (said to be dated 12 May 2017) was in fact the same statement/complaint made by D1234 on 25 April 2017: see HOM002492_0002-0003. The 12 May 2017 stamp appears to be a reference to when it was received by Harriet Harman's office: see HOM002492_0001.

[280] Mr Collier did not consider the need to revise his views in light of the read-in summary: see his supplementary report at INQ000158_0048.

conclusions in relation to it:[281] namely that the use of force was lawful under Rule 43(10) under the Detention Centre Rules; it was used as a last resort; it was necessary to do so; the selection of removal techniques was reasonable; and it was proportionate in the circumstances to apply handcuffs and carry D1234. However, Mr Collier also concluded: (a) that it was not proportionate to permit staff to wear a balaclava;[282] and (b) that the execution of certain techniques was poor.

267. G4S accepts that, as a matter of protocol, staff should not have been wearing balaclavas during this incident, given the absence of any fire risk (although observed that no criticism in that regard is made in the NTRG report, which refers in passing and without comment to balaclavas a part of the PPE kit).[283] However, it does not agree with Mr Collier's language of 'proportionality' in relation to the same, as the wearing of a particular garment by staff (here balaclavas) does not, itself, form part of the force used against D1234 (so as to impact any proportionality analysis).

268. Beyond that particular point about the appropriate of wearing balaclavas, Mr Collier's concerns in relation to the incident are confined to questions of technique. That is not to minimise them: indeed, subject to the particular points below, G4S accepts these criticisms (as Mr Dix did in his live evidence).[284] However, it is to recognise the limited and focused nature of those concerns. This incident is, in Mr Collier's view not one in which force should not have been used at all; or that the particular techniques adopted were inappropriate to the circumstances. Rather, they were the right techniques, but incorrectly applied by staff.

269. While Mr Collier's assessment is understandably (given the nature of the Inquiry) focused on the 'areas of concern', he is right to pick up on examples of good practice within this incident, in particular (at paragraph 150 of his first report): "*Good attempts at de-escalation were made and DCM Dix gave clear and concise instructions and numerous opportunities*

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[281] INQ0000111_0043, paras 158-166

[282] At paragraph 141, Mr Collier observes that: "*Under normal circumstances I would have expected all helmets to be removed, however if there is a risk of spitting the helmet full face visor offers protection against being spat at. None of the statements, or my observations, give evidence of the intention to spit*". However, the footage does plainly demonstrate D1234 in fact spitting at staff; and Mr Collier subsequently observes at paragraph 153 that: "*…I do agree that maintaining full PPE was justifiable due to the threat of spitting*".

[283] HOM002495_0003.

[284] Steve Dix 9 March 2022 31/11-35/17.

to comply". He also rightly points out that staff "*faced a difficult and challenging detainee, made more difficult by him being naked*" (paragraph 149).

270. Turning, then, to some of the particular aspects of the incident, including those upon which Mr Collier focuses:

271. The use of force was planned, to comply with removal directions: i.e. to take D1234 from E wing to the Tascor escorts, who would take the detained person to Stansted Airport. Although not available to the Inquiry, the NTRG report into the incident notes that: "*On the footage there is an initial briefing of the staff at Brook House. This is to a high standard and gives an insight into the current situation and the provisions in place, such as being on a constant supervision and having been offered medical treatment etc.*"[285]

272. Mr Collier's report demonstrates (see paragraph 124) that repeated attempts were made to attempt that D1234 would walk to the escort vehicle – i.e. such that no force would be used. Not only did these attempts fail, but D1234 had stripped naked and started chanting when the removal was attempted. It was clear that: "*D1234 was not going to comply and resort[ed] to the extreme measure of removing his clothes to prevent the removal*". As Mr Collier further observes (paragraph 136), "*All reasonable efforts were made and it is demonstrated through the footage when staff first enter the room that; D1234 was not going to comply and resort to the extreme measure of removing his clothes to prevent his removal*".

273. In that regard, it is to be noted that Mr Dix asked for the camera to be pointed towards the ceiling for a short period while attempts are made to wrap a sheet around D1234, following which the camera returns to recording the incident. Mr Dix gave that instruction (as he explains in the footage) for the protection of D1234's modesty and dignity. It does not prevent the incident being recorded, as audio recording continues during this [brief] period. Indeed, as soon as a sheet is wrapped around D1234, the video recording of the incident resumes. Mr Collier refers to paragraphs 3.32-3.33 of PSI 04-2017. The effect of those paragraphs is that it will only be in exceptional circumstances – such as violent/aggressive behaviour – where there is an overriding requirement to record a partially clothed detained person; and that where there is footage of intimate body parts, "*consideration must be given to pixilation of the footage*". It is precisely because of the strictures in paragraph 3.32 that Mr Dix called for the camera to be pointed away from D1234, once it was clear that it would otherwise record video while he was naked. Mr Dix's actions in that regard are entirely

[285] HOM002495_0003.

consistent with PSI 04-2017. Mr Collier is right to point out (paragraph 139) that there was some non-compliance with paragraph 3.33 of PSI 04-2017 given the lack of pixilation of the footage, where D1234's intimate body parts are visible. G4S accepts that, although notes that these appear on the footage incredibly briefly. It may even be the case that staff did not realise that body parts had been captured, given Mr Dix's swift direction to point the camera away until a sheet could be used to cover D1234.

274. Turning to the three particular criticisms made by Mr Collier: (a) handcuff technique; (b) carry technique; and (c) head control:

(a) *Handcuff technique* – It is right, as Mr Dix accepted in evidence (now with the benefit of hindsight and a better understanding), that handcuffs should not have been applied to D1234 while in the seated position. Mr Collier makes this observation at paragraph 166 of his first report; as does Rhiann Gilbert of NTRG.[286] However, when CTI questioned Mr Dix about this aspect, she combined two points: (i) the application of the handcuffs in a seated position; and (ii) the misapplication of the handcuffs resulting in one wrist being almost fixed in a flexed position.[287] That, though, is to conflate two separate points. First, G4S staff admittedly handcuffed D1234 from a seated, rather than a standing position. There is no suggestion, however, contrary to CTI's line of questioning, that doing so would necessarily have caused any pain to D1234. Indeed, to the contrary, the NTRG report observes that: "*this did not appear to cause any additional distress*".[288] Subsequently, at paragraph 144, Mr Collier states that:

> "When the move reaches the discharge area Tascor staff are waiting to take over. The first action was to remove the handcuffs and move them to the front. The footage later shows that the handcuffs were wrongly applied and resulted in one wrist being almost fixed in a flexed position. This results in every movement from the handcuffs causing pain and potentially causing damage to the wrist. Once the handcuffs have been applied the waist restraint belt is applied"

From this context, the misapplication of the handcuffs in a flexed position, leading to pain, is plainly a reference not to the initial application of handcuffs by G4S staff, but the subsequent re-application of handcuffs by Tascor escort staff once D1234 had been handed over to them. Accordingly, it is not right that Mr Collier suggested that handcuffing technique of G4S staff would have caused any pain to D1234, and that suggestion should not have been put to Mr

[286] HOM002495_0004.

[287] Steve Dix 9 March 2022 31/11-32/16.

[288] HOM002495_0004.

Dix. Indeed, Mr Dix made the very point in evidence that "*when applying handcuffs, you never want to cause unnecessary pain*".[289]

(a) *Carry technique* – Mr Collier's criticism in this respect was not that a carry should not have been used, but rather it was "*poorly managed and executed*": paragraph 152. Mr Collier's view is that "*the staff appeared unsure on what to do and they clearly could not recall the training delivered for this technique*": ibid. Neither at paragraph 152, nor at paragraph 142 does Mr Collier actually explain what was wrong with the technique used by staff; nor did he do so in oral evidence, save for a reference to following lifting and handling guidelines, and starting from the correct position.[290] The NTRG report of Rhiann Gilbert is more instructive, observing that the issue was that: "*the detainee's head was brought forward rather than controlled from the rear*".[291] However, the NTRG balances this legitimate criticism with the observation that: "*a decision to carry [D1234] was made by the supervisor to carry him with good guidance and instruction on how to lift*".[292] Further, just as Mr Collier explains at paragraph 142 that: "*Carrying should only be used as a temporary manoeuvre and once it achieves its aim the detainee should be placed back on their feet*", so the application of precisely that principle is recognised by Rhiann Gilbert: "*The detainee was offered the opportunity to walk throughout the carry. This is good practice.*"[293]

(b) *Head control on the ground* – Mr Collier's third criticism at paragraph 143 (and 153) is that: "*when going to ground staff appear to be pushing D1234's head down. This is not consistent with controlling the head and could present a risk of injuries…*" It should be noted both that: (a) Mr Collier's view is based on the footage, and he is not conclusive, noting only that staff "*appear*" to be pushing the head down; and (b) Rhiann Gilbert of NTRG did not make this observation or criticism. As such, Mr Collier is undoubtedly correct that it would have been inappropriate, unnecessary and improper for staff to have pushed D1234's head down if that had occurred, but the evidence does not suggest that it did. As noted above, Mr Collier is far from certain in his viewing of the footage. More than that, though, the Inquiry is invited to accept

[289] Steve Dix 9 March 2022 33/1-2.

[290] Jonathan Collier 30 March 2022 55/19-56/5.

[291] HOM002495_0004.

[292] HOM002495_0004.

[293] HOM002495_0004.

the conclusions of the PSU following its detailed and thorough investigation. The resultant report at paragraph 7.2.4-7.2.5 found that:[294]

> "DCO Olayie, who controlled D1234's head at this point, recalled D1234 made himself "very rigid" and said he controlled his head so it did not hit the floor or anywhere else. This was corroborated by the other G4S officers present who all said at interview they did not see D1234 hit his head on the floor…The video footage did not show two officers controlling D1234's head but it showed D1234 repeatedly trying to turn his neck."

275. In short, and subject to the criticisms of technique made by Jonathan Collier, the Inquiry is invited to endorse the overall conclusions of the PSU made in relation to this incident, informed as they were from not only detailed and considered investigation, but also the independent input of the NTRG report (indeed, itself presented at the request of Mr Collier); in particular those at paragraphs 7.2.18-7.2.21:

> "7.2.18 The evidence showed that D1234 offered considerable and sustained resistance to the officers' legitimate use of force in seeking to restrain and control him in the circumstances. Reasonable steps were taken by staff in the first instance to encourage D1234's compliance. In the face of his continued verbal non-compliance and his physical attempts to frustrate his removal, each of the teams was justified in using force in accordance with the respective Operating Standards.
>
> 7.2.19 The handcuffs were removed at the earliest opportunity; one after D1234 was sufficiently under control by TASCOR officers and the other after he had stopped physically resisting the officers once in the vehicle. The leg restraints and WRB were removed at Stansted Airport once D1234 was informed the flight was cancelled and his compliance significantly improved.
>
> 7.2.20 While some aspects such as the application of the ratchet bar handcuff by G4S and the head control from the front during carrying D1234 in handcuffs were not applied to taught standards, they were not considered to have negatively impacted on the extent and duration of the use of force.
>
> 7.2.21 After careful consideration it was concluded that no excessive force or more force than necessary was used and the force used was reasonable, proportionate and justified in the circumstances as confirmed by the NTRG review and therefore the complaint was unsubstantiated"

276. Accordingly, where the use of force was in principle justified, as were the techniques selected for use, such that the only extant criticism (albeit some of it valid) pertains to the

[294] HOM002750_0029.

application of those techniques in an adrenaline-driven[295], 'live' environment, it cannot be said that the incidents reflects any meaningful engagement of D1234's Article 3 rights. Indeed, the conduct of staff was not to undermine D1234's humanity, but to prioritise it. The NTRG even suggests they went too far in doing so: "*Maintaining the detainee's dignity throughout appeared to be a priority, at times possibly to the detriment of effective restraint*".[296] Further, any pain or distress suffered by D1234 in the course of the incident: (a) did not meet the high Article 3 standard; and (b) was essentially inherent in the nature of the legitimate activity being carried out by staff – i.e. using force to effect D1234's removal given his non-compliance. Staff repeatedly sought his voluntary compliance and repeatedly gave him the opportunity to walk during his transfer, rather than be carried. Indeed, even when it comes to the misapplication of the otherwise-permitted techniques (through applying handcuffs in a seated position), the NTRG conclusion was that: "*this did not appear to cause any additional distress*".[297]

Row 4: Two self-harm incidents on 8 April 2017

277. This pair of self-harm incidents involving D1527 and D1732 occurred on April 2017 and it is alleged that they occurred because the relevant detained persons were not given medication. Neither of these incidents were explored (certainly not substantively) during the course of the Inquiry's oral hearings. G4S therefore addresses them, in turn, based on the documentary material available.

278. In relation to D1527, a helpful overview of the narrative can be drawn from the PSU's investigation report dated 22 February 2018 at paragraphs 7.101ff;[298] as well as some of the underlying medical records.[299]

279. D1527 arrived at Brook House from HMP Belmarsh on the evening of 4 April 2017 (4 days before this incident) without his prescription medication for depression.[300] Needless to say, that cannot be the responsibility of the medical or other staff at Brook House. If there is any

[295] See Steve Dix 9 March 2022 35/9-10.

[296] HOM002495_0005.

[297] HOM002495_0004.

[298] CJS001107_0031

[299] See, e.g., CJS001002

[300] CJS001107_0031

fault in relation to that, it is likely to lie at the feet of those arranging D1527's transfer from HMP Belmarsh (rather than those dealing with his arrival).

280. As Karen Churcher explains in her evidence:[301]

> "This medication should have arrived at Brook House with him from the prison. If medication doesn't arrive with detainees, it needs to be prescribed and we also need to check that they are on the medication that they say they are and this has been signed off by a doctor."

281. D1527's medical notes also disclose that D1527 had an appointment with Dr Chaudhary on 5 April 2017 (seemingly within 24 hours of his arrival at Brook House and his anti-depression medication was prescribed.

282. The PSU report also notes that "*detainees are risk assessed regarding how their medication will be dispensed and D1527 was advised he should collect his medication at 13:30 hours daily*";[302] which D1527 acknowledged.[303] That is a principle with which Dr Hard agrees:[304]

> "There is an important principle to consider in regard to the provision of treatment within secure settings which is that there ought to be an appropriate level of responsibility given to the patient to be concordant with their treatment as this cannot otherwise be enforced upon them. I would not expect nursing staff to routinely transport medication onto the wing to deliver to a detained person's room. Ultimately, there needs to be a careful balance between encouragement of personal responsibility for treatment versus being coercive or applying contingency management."

283. The PSU report on to point out that during an ACDT review on 7 April 2017 (at 1600),[305] D1527 pointed out that he had not had his anti-depression medication "*lately*"; and was advised by the nurse that this was "*now in stock and he needed to collect it at lunchtime each day*".[306] D1527 also told the nurse that "*he had occasional thoughts of self harm but he agreed he would approach staff*" if he felt he would act on those thoughts.[307]

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[301] DWF000022_0017, para 75

[302] CJS001107_0031, para 7.102

[303] CJS001049_0003

[304] INQ000075_0047, para 5.75

[305] See CJS001049_0003

[306] CJS001107_0031, para 7.103. By contrast, D1527's medication for his neck would not arrive until 8 April 2017.

[307] CJS001107_0032, para 7.104; see also the ACDT review form at CJS001049_0003

284. D1527's next case review was on the morning of 8 April 2017 (at 11:25am). He initially refused to participate, and was reminded by the case manager "*to attend healthcare this afternoon as his antibiotics were due to be delivered*".[308] The case manager also checked with other stuff (DCO Mankellow) who reported that D1527 had been in good spirits that morning and, as a result, his observations were reduced to once every two hours.[309]

285. The next ACDT review is recorded as having taken place at '01.15' on 08/04/2017. From context, however, it would appear that this review in fact took place after that described immediately above. It may be, therefore, that it occurred at 01:15 on 9 April 2017 (i.e. shortly after midnight on the 'night of 8 April'). That would accord with the chronology of events and documentation. During that review, D1527 displayed "*superficial scratches to his left wrist*"; said he would not make these again; and confirmed (twice) that he did not have any thoughts at the time of hurting himself.[310] His observations were increased to hourly; and there were no concerns (or reports of further self-harm) at his next review at lunchtimes on 9 April 2017.[311] By 10 April 2017 the ADCT review records that D1527 had been taking his medication; and was feeling better for it.[312]

286. In relation to this incident, G4S submits that:

(a) First, any harm to D1527 was very low – with only superficial scratches to one wrist, which did not require medical intervention.[313]

(b) Secondly, it is unlikely that this was caused by D1527 not taking his medication. Karen Churcher's evidence in this regard is that:[314]

> "D1527 was on a very low dose of [*] was on 10mg, which is below the minimum dose. You can miss one day of this medication with no side effects, depending on the level of dose or how long you don't take it for you can then start to experience flu-like symptoms. It takes two weeks to get to a therapeutic dose when you begin taking this medication so it would take around two weeks to decline and start feeling low again. D1527 was on a very low dose therefore he would have only experienced very mild side effects from missing a couple of days of medication" (emphasis added).

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[308] CJS001049_0004

[309] CJS001049_0004

[310] CJS001049_0005

[311] CJS001049_0005-0006

[312] CJS001049_0008

[313] CJS001002_0032

[314] DWF000022_0017, para 76

After missing a *maximum* of 4-5 days of medication, he would therefore not have yet started feeling low as a result of withdrawing from the medication.

(c) Thirdly, insofar as D1527 scratched himself as a result of not having received his medication, that was not the fault of staff at Brook House. D1527 arrived at Brook House without any medication; and within 24 hours was seen by a GP and a prescription made. He was appropriately assessed to be able to collect his own medication; and was due to collect and take these on the afternoon of 8 April 2017. He had acknowledged this and was specifically reminded shortly before lunchtime on the same day. The healthcare staff therefore had D1527's medication ready and had given him reminders to collect it. Ultimately, they are not at fault if he did not do so an hour or two later.

287. In relation to D1732, again the only evidence is documentary and scant. There is limited witness evidence from Marina Mansi[315] and Babatunde Fagbo[316] and the incident was not explored with the latter during his oral evidence.

288. What emerges from the documentary evidence is that on 8 April 2017 D1732 cut his forearm as a result of becoming frustrated with not having received medication; that cut required hospital treatment of 18 stitches.[317]

289. What does not emerge from the material available is any basis on which the Inquiry could conclude that: (a) this should or could have been foreseen by Brook House healthcare staff; and/or (b) that healthcare staff were responsible for getting medication to D1732 and failed to do so. On the contrary, D1732's 9 April ACDT review observed that:[318]

> "D1732 had been very frustrated with healthcare due to not receiving his medication, healthcare state that he missed an appointment and therefore the doctor had not renewed his prescription, whereas D1732 says that he didn't know he had an appointment. Whilst things were being sorted D1732 had made a cut to his arm which required hospital treatment."

290. Accordingly, when the incident occurred, it appears that D1732 did not have a 'live' prescription for any medication; and any failure to renew his previous prescription occurred

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[315] BDP00005_0011

[316] BFA000001_0012

[317] See, e.g., CJS003569_0001, CJS002305_0001, CJS001202_0010, etc.

[318] CJS0073689_0001

because D1732 had failed to attend an appointment with the doctor – rather than as a result of any staff failure. There are subsequent regular observations of D1732 for the next four days;[319] and by the next day (9 April) D1732 had been prescribed and received medication and confirmed that if he had any problems would speak to someone; risk of further harm was deemed to be low.[320]

Row 5: D2077 sews his lips together in protest on 9 April 2017 and refuses food

291. This incident concerns an act of protest taken by D2077 against the Home Office, in the form of sewing his lips together.[321] It was not an incident explored with any witness in the course of the Inquiry's oral hearings.

292. An important aspect to the Inquiry's approach to this incident is an appreciation that D2077 had originally been detained in Tinsley House in 2016, from which he was released, before being re-detained in Campsfield House on 31 March 2017, before being transferred to Brook House on 6 April 2017. For the Inquiry's convenience, a summary of the chronology is set out in the Annex to Theresa Schleicher's statement.[322]

293. That is important context because, in taking the appropriate response to the incident on 9 April 2017, the Home Office were already fully apprised of D2077's background and history.[323] As the Annex to Ms Schleicher's statement makes clear, a Rule 35(3) report had already been prepared in respect of D2077 while he was in Tinsley House, on the basis of which he was released from detention on 23 June 2016. Nevertheless, notwithstanding that report, he was re-detained in 2016 (and notwithstanding representations made by D2077's solicitors to the Home Office). Ms Schleicher's evidence also points out that D2077 received a Rule 34 examination on arrival at Brook House.[324]

294. The combination of D2077's initial medical screening with his Rule 34 appointment the next day made clear that D2077 had previously self-harmed and was feeling low due to lack of

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[319] CJS002305_0001

[320] CJS0073689_0001 and CJS002889_0003

[321] CJS000611_0002

[322] BHM000031_0102ff

[323] See also DL0000195

[324] BHM000031_0102, para (23)4

access to medication; but did not have thoughts of deliberate self-harm at the time or suicidal thoughts; and ultimately medication was prescribed.[325]

295. In light of the fact that D2077 had informed healthcare staff on 6 April 2017 that he had no thoughts of deliberate self-harm (and met with the GP on 7 April 2017); the healthcare team cannot be said to have been at fault in not preventing him from sewing his lips together on 9 April 2017 in an act of protest. D2077 also refused to consent to the nurse removing the threads until 12 April 2017.[326] In the circumstances, the staff response was appropriate:

(a) On discovering what D2077 had done, a 'first response' team was summoned and healthcare and officers arrived "*within minutes*".[327] He was placed the same day on constant supervision and an ACDT. This was reduced to hourly checks on 10 April 2017.

(b) The Home Office was informed on 9 April 2017 (i.e. the day of the incident) that D2077 "*has been placed on constant supervision after he was discovered stating that he was going on a hunger strike and then showed that he had sewn his lips together*".[328]

(c) Karen Churcher's [unchallenged] evidence is that because D2077 had attempted to sew his mouth shut, his food and fluid intake would have been "*constantly observed*" and "*documented on his observation sheet*".[329] Even though D2077 had sewed his lips together, he was still "*taking in small amounts of food and fluids through a small opening*".[330] He also was seen by a doctor (Dr Oozeerally) on 10 April 2017.[331]

(d) On 12 April 2017 Dr Oozeerally completes an IS191RA and requests that D2077's detention be reviewed on the basis that he has a previous Rule 35 report.

296. D2077 was released shortly thereafter – on 20 April 2017 – a decision taken by the Home Office.

297. In short, therefore, there can be little substantial criticism of the conduct of the healthcare staff at Brook House: the Home Office had determined that – notwithstanding D2077's

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[325] DL0000200_0003-0004

[326] DL0000200_0004

[327] BDP00005_0017, para 54

[328] DL0000197_0005

[329] DWF000022_0013, para 55

[330] HOM0331741_0008, para 46

[331] DL0000200_0005

earlier Rule 35 report, he was to be detained at Brook House.[332] He received a medical screening and Rule 34 assessment on arrival and reported no intention to self-harm. D2077 sewed his lips together in protest against the actions of the Home Office; with whom his solicitors were at the time corresponding regarding his case. As soon as Brook House staff discovered what he had done they promptly: took him to healthcare, informed the Home Office, and placed him on constant supervision. D2077 refused to have the thread removed from his lips for a number of days – "*until he was released*"[333] – i.e. it was an act of protest on his part (and his representatives were being kept abreast of developments by Brook House staff).[334] In the interim, healthcare staff ensured that D2077 was "*eating, drinking and smoking through a small opening*"[335] and he was given regular pain medication for pain relief. D2077 was released little more than a week afterwards.

Row 6: Use of force against D2416 on 11 April 2017

298. This incident is one, in respect of which Mr Collier changed his mind, having reviewed the BWC footage. In Mr Collier's first report (at paragraphs 424-429), he originally concluded, based on the material then available to him, that force had been used on D2416 only as a last resort, and it met the principles of 'necessary, reasonable, proportionate'.[336] He had no concerns beyond the bare fact that the detained person was undressed during the course of this removal.

299. That was a view that Mr Collier subsequently revised at paragraphs 34-36 of his second supplementary report.[337]

300. Before dealing with Mr Collier's updated views, it is worth pointing out the nature of this use of force, which was planned: it involved the restraint of D2416 by staff in light of the detained person's failure to walk voluntarily to the Tascor escort staff, who would take him to his charter removal flight to Germany. The narrative of the incident is set out both in the

[332] DL0000195

[333] DL0000200_0005

[334] DL0000226_0052

[335] DL0000200_0005

[336] INQ000111_0103.

[337] INQ000177_0009.

compiled Use of Force documentation;[338] as well as in the witness statement of Ben Shadbolt at paragraphs 153-160.[339] In short, in light of D2416's failure to comply with the lawful instruction to move from his room to the escort, he was restrained and handcuffs were applied to move D2416. His head was supported initially; and then again subsequently while D2416 was on the stairs: see paragraph 422 of Mr Collier's first report.[340]

301. Based on this brief narrative, and as derived from the Use of Force reports,[341] Mr Collier was satisfied that the use of force was reasonable and proportionate. In light of the footage from the body-worn camera, however, he felt it appropriate to update certain (but not all) of his initial conclusions.

302. It should be noted that, even having reviewed the body-worn camera footage, Mr Collier makes no criticism of the officers' execution of the particular techniques deployed (e.g. by suggesting that these were misapplied or incorrectly carried out).

303. As noted above, G4S recognises the expertise of Mr Collier, and does not here seek to invite the Inquiry to go behind his *opinions* (as expert), where they are based on clearly-established facts. However, in relation to this incident, it is respectfully submitted that certain of Mr Collier's *factual* observations or assumptions are not (or at least not necessarily) correct.

304. Taking each of Mr Collier's updated observations in turn:

    (a) First, Mr Collier observes at paragraph 34 that a period of 26 seconds elapsed between the team entering the room and the application of force. He considered that that period was not sufficient "*to explain and try persuasion for compliance*". There is no suggestion that the team (in particular DCM Farrell) did not make an attempt to obtain voluntary compliance (to avoid the need for force to be used), but only that this attempt was too short in duration. For this reason, Mr Collier "*changed*" his view on force being the last resort. In his written evidence, he did not clearly explain how that view had changed. Neither did he do so orally; instead his affirmative response was in response to the leading question: "*it's also an example, isn't it, of force being used not as a last resort?*".[342] The Inquiry is invited therefore to place limited weight on that

[338] CJS005630

[339] SER000441_0022.

[340] INQ000111_0102

[341] CJS005630

[342] Jonathan Collier 30 March 2022 67/13-14.

response. Instead, G4S submits that the fairer reading of Mr Collier's evidence is that his criticism of the lengths that the team went to in order to seek voluntary compliance does not show that force was not the last resort, but rather it was not necessarily the last resort. Attempts were made to seek voluntary compliance, and the Inquiry is invited to take a realistic approach to the utility of further efforts, in circumstances in which D2416 had told staff that the would not go compliantly.[343] G4S does not demur from Mr Collier's observation that further efforts could have been made, for more than 26 seconds, but points out that these are points of constructive criticism in respect of techniques that staff were deploying. It is not the case that staff did not seek voluntary compliance; they did so. Mr Collier's constructive criticism (which G4S accepts) concerns best practice in seeking voluntary compliance – rather than suggesting that no attempts were made at all (which would have been a serious criticism).[344]

(b) Secondly, at paragraph 35, Mr Collier 'questions' why DCM Farrell: [345]

> "insisted for the head support to be applied for moving down the stairs when D2416 was compliant, although he was verbally challenging but not offering a threat or risk at the time. There is nothing to support the comment in paragraph 422 that D2416 was trying to use his feet on the railings to disrupt the movement at this stage and D2416 only attempted this when on the stairs".

Mr Collier does not categorically say that D2416 was not trying to use his feet on the railings to disrupt movement. Indeed, he cannot; but rather suggested that the video footage did not [additionally] *support* this. He expanded on this point in oral evidence, noting that: "*if someone was struggling or attempting to resist the removal, you would hear staff giving instructions... So there was no verbal interaction between the staff to really evidence that there was any problem with the movement*".[346] As such, Mr Collier has drawn the factual conclusion (rather than an expression of expert opinion) that D2416 had not used his feet on the railings because, if he had done so, one should have heard conversation in the footage reflecting that. Respectfully, that it was a question of fact, on which Mr Collier is not in a position to give evidence. Indeed, Mr Collier recognises that certain aspects of the incident are not shown on the footage to

[343] SER000441_0022; CJS005630_0009

[344] Jonathan Collier 30 March 2022 67/21-68/1.

[345] INQ000177_0009

[346] Jonathan Collier 30 March 2022 65/21-66/7.

preserve D2416's decency.[347] In those circumstances, G4S respectfully submits that the Inquiry has no real basis to go behind the contemporaneous accounts given by staff in the use of force documentation, which expressly state that D2416 was using the rails to disrupt movement: "*D2416 whilst bring escorted down the staircase was putting his feet onto the opposite handrail attempting to prevent him from being taken to the overseas escorts*";[348] "*again on the way down the stairs D2416 tried to put his foot on the railings*";[349] and "*D2416 attempted to move his feet on the railings to stop walking down*".[350] It is also the position as given in Annex 3 to Dr Bingham's statement.[351] The Inquiry should not digress from those clear explanations, where:

(i) Mr Collier's suggestions to the contrary are not expressions of expert opinion, but stray impermissibly into matters of fact.

(ii) Mr Collier's suggestions, in any event, are not that D2416 could not have disrupted in this way, but rather Mr Collier had not heard instructions or conversations in the footage that he would have expected to, if he had.

(iii) Were the Inquiry minded to make factual findings contrary to the officers' account, as a matter of fairness it should have – but did not – put any such conclusions to DCM Farrell, from whom it heard oral evidence.

(c) Thirdly, Mr Collier observes, based on the footage, that:[352]

> "D2416 is left naked in the presence of at least seven staff from 08:50-17:35. This appears to be whilst a sheet is being found to cover him; if this is correct, I find it unacceptable and degrading. There was ample opportunity to arrange for clothing to be made available beforehand and for only the necessary staff to be present whilst D2416 was undressed."

It is right to observe that, again, Mr Collier is not categorical in this view. It is conditional: if his factual assumption were right, he would find that unacceptable. Mr Collier is right to recognise that the footage does not necessarily disclose any conduct which is unacceptable or degrading. Rather, he suggests that it is possible that it might.

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[347] INQ000177_0009, para 35.

[348] CJS005630_0010

[349] CJS005630_0014

[350] CJS005630_0019

[351] BHM000033_0183.

[352] INQ000177_0009, para 36.

A finding that conduct was unacceptable is not one that the Inquiry should make without clear or plain evidence, especially where the expert was unwilling to make such a categorical finding. Again, it certainly should not do so where the accuracy of Mr Collier's factual assumption could have been – but was not – explored with either DCM Farrell in his oral evidence, or directly with DCO Shadbolt through the Rule 9 process (given that Rule 9 questions were asked of DCO Shadbolt).[353] Based on the documentary evidence that the Inquiry does possess, it cannot be said that the officers' conduct was degrading towards D2416, given that:

(i) There is no basis to suggest that staff knew or anticipated that D2416 would be naked. The reason why a towel was used rather than seeking to find clothing in advance was because it was not deemed safe at the time.[354] It should be recalled that the discovery that D2416 was naked appears to be after the team had been sent in to use force.[355] DCO Timms' report gives evidence that D2416 was, in fact, expressly asked more than once if he wanted to put any clothes on, but refused to answer.[356] The enquiry of D2416 regarding clothes is corroborated by the account of DCO Wright.[357]

(ii) DCO Shadbolt expressly asked female staff to step away from the door to protect D2416's dignity; and again called to Tascor staff to check that there were no females waiting for D2416.[358]

(iii) Staff (repeatedly) wrapped a towel around D2416's waist specifically to protect his dignity.[359] They cannot be blamed for it falling off: (a) generally; or, in particular (b) as a result of D2416's own kicking action.[360]

305. Accordingly, of Mr Collier's three criticisms of the use of force in this incident, G4S accepts that the efforts to achieve voluntary compliance could have been more sustained, but points out that efforts were still made; and invites the Inquiry, in the circumstances, to take a

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[353] See SER000441_0001.

[354] SER000441_0023, para 158.

[355] CJS005630_0009

[356] CJS005630_0014

[357] CJS005630_0019

[358] SER000441_0023, para 155-156.

[359] SER000441_0023, para 156.

[360] SER000441_0023, para 156.

realistic approach to the [f]utility of further efforts. Nevertheless, the fact that more attempts could have been made is a valid learning point; but the fact that it is a matter of degree, of improving negotiation technique, demonstrates that this aspect does not come close to engaging the high Article 3 threshold. Neither does the *factual* issue of whether D2416 using his feet on the railings to disrupt movement. In relation to D2416's naked state, this does not come close to 'degrading' treatment for the purposes of Article 3. The evidence before the Inquiry makes plain that every step taken by staff – indeed repeatedly – was for the purpose of maintaining D2416's dignity: from wrapping a towel around him (repeatedly), to checking that there were not female staff in the vicinity. Mr Collier's own observations in this regard are highly conditional and lack a proper factual basis. Rather, the evidence in fact suggests that staff (in fact repeatedly) offered D2416 the opportunity to put on clothes before his transfer. Simply put, where he ignored those genuine offers, his subsequent movement without clothes, but using a towel, cannot be seen as degrading.

Row 7: Discussion of a 'banquet' on 19 April 2017

306. This alleged incident concerns a suggestion that Daniel Lake had been laughing and joking with Daniel Small and Kerry Coppin about "*eating a feast or banquet*" whilst on escort duties in front of a detained person who had been on hunger strike for six weeks.[361]

307. The source of the allegation is a video diary provided by Callum Tulley – rather than a video recording of Mr Lake allegedly making these comments to comments; let alone of the alleged underlying incident, itself. No information has been given about the identity of the relevant detainee or exactly when the comments were said to have been made to him. Without that information, Mr Lake cannot properly respond to the allegation; nor can other Core Participants (including G4S) seek to identify any relevant materials or documentations. With that in mind, understandably Mr Lake had no recollection of the conversation to which Callum Tulley refers or of doing the bed watch duty.[362]

308. The evidence goes no further, in practice, than Mr Tulley's video diaries; and in the absence of the particulars identified above, the Inquiry cannot – and certainly cannot fairly – come to any meaningful conclusions about the alleged conduct, including whether or not it occurred. By way of simple example, the Inquiry has heard much of 'macho' talk in the

[361] See TRN0000036_0005, TRN0000037_0022.

[362] BDP000002_0014 paragraph 44; Daniel Lake 1 March 2022 37/15.

staff room, often exaggerated or wholly divorced from the reality of underlying incidents (if, indeed, the conduct described even occurred at all). The suggestion that a DCO could eat a 'feast' or 'banquet' in a hospital room next to a detained person smacks of that category of tall stories. Being realistic, it is possible that a DCO ate their own meal next to the detained person, but:

(a) It is highly unlikely that such a meal would have been a 'feast' or 'banquet' (whatever is suggested by those terms).

(b) Where the DCO was on escort duty, and required to watch the detained person while they were at the NHS facility, it would have been necessary for the DCO to maintain a watch on the detained person, which would have included during times when the DCO needed to eat.

309. Of course, it would have been highly insensitive and inappropriate for a staff member to make a point about the quantity of food that they were eating to a detained person who was on hunger strike (as Mr Lake, himself, accepts[363]). However, even on Mr Tulley's account, there is no suggestion that Mr Lake did any such thing: the allegation is no more than he 'ate' the feast/banquet in front of the detained person; not that the said or did anything more in relation to it or the detained person. Callum Tulley's discomfort at Mr Lake laughing about this matter is not a suggestion that Mr Lake did so in front of the detained person, but rather than it was callous to do so at all (i.e. with other staff).

310. In the premises, there are not enough details in the allegation; as well as insufficient evidence for the Inquiry to come to any factual conclusions in relation to this alleged incident. Should it even be an issue, this incident cannot be said to cross the line on Article 3 where the evidence (thin as it is) goes no further than to suggest Mr Lake simply ate a meal in front of a detained person on hunger strike; with no further conduct or comments towards him; and with any laughing about doing so occurring subsequently with other staff (and not in the presence of the detained person).

Row 8: Incidents involving D119 and DCO Fagbo (21 April) and DCO Munroe (22 April)

311. This pair of incidents is demonstrative of the approach taken by G4S to the use of inappropriate language and an inappropriate attitude taken by its officers towards detained

[363] BDP000002_0014 paragraph 44.

persons: even where such language was used in the context of an argument or heated atmosphere between the officer and a detained person. In such circumstances, the detained person could not be disciplined; and even where their language or attitude mirrored that of the DCO, G4S recognised that was not an excuse for the officer's misconduct. Indeed, precisely because the officers were placed in positions of authority with responsibility for the detained person's care, meant that their conduct was to be scrutinised in a manner that the detained person's was not. This pair of incidents demonstrates G4S' zero tolerance towards officers engaging in the use of bad language towards detainees, where that conduct has come to the Company's attention. The strict sanction of dismissal as a consequence of these incidents was seen by the officers concerned as harsh; but it makes plain the company's unwillingness to tolerate its officers 'mouthing off' or using inappropriate language or tone towards those in their care. Notably, both investigatory/disciplinary processes (and indeed one had completed) before Panorama was aired. The Company's approach thus cannot be said to have been reactive to the programme in the short-term, but rather a genuine reflection of its concern and care for those in its custody.

312. This matter came to G4S' attention by virtue of complaints made by D119, himself,[364] as well as D720.[365] The former's complaint (dated 22 April 2017) addressed a matter concerning his cleaning duties, which was not substantiated,[366] but relevantly for present purposes also contained allegations that on 21 April 2017 a group of officers had "*antagonised [him] for approximately 1 minute*", including laughing at him and calling him a 'derogatory and scandalous name', "*such as little girl, waste of space*"; and making reference to the fact that while he would be locked up, they would be going home to their families, which "*set me off as you can imagine*". D720's complaint was received on 23 April 2017. It contains more detail: (a) an allegation that on 21 April 2017 officers "*laughed and taunted*" an unnamed detained person (D119), calling him a 'waste', 'little girl' and saying "*I'm going home now*";[367] and (b) an allegation that on 22 April 2017 'Shay' (DCO Munroe) referring to D119 as a "*waste man*", trying to antagonise him and re-ignite the argument

[364] CJS001594

[365] CJS005888

[366] CJS001594_0003

[367] CJS005888_0002

from the night before. D720's complaint continued that DCO Munroe contended that she was not talking about D119 (and swore on her son's life to that effect), but clearly was.[368]

313. G4S responded to the complaints swiftly, with the matter being referred to the PSU on or by 24 April[369] and back to the Company for investigation by the PSU on 25 April 2017.[370] Notably, the documentary evidence shows that D720 in fact withdrew his complaint, but nevertheless it was (rightly) included with the paperwork for D119's extant complaint, given that it contained material relevant to it.[371] That was not the action of a body seeking to 'shut down' or pay lip service to complaints. Such an organisation would have closed off and subsequently disregarded D720's complaint; but Karen Goulder (Administrator) specifically included that complaint within the paperwork for D119's complaint.

314. There is a clash of evidence in relation to what occurred during the incidents, themselves – principally between the accounts given by the detained persons (D119 and D720) and those of the officers, whose conduct has been subject to scrutiny – DCO Fagbo and DCO Munroe. Unfortunately, the Inquiry does not have witness statements from D119 or D720, in order to better understand their accounts and/or to test their evidence. It did, however, hear from both DCOs Fagbo and Munroe.

315. In light of that clash, G4S invites the Inquiry to accept the evidence of the other officers who witnessed the incident[s], and who were interviewed by Michelle Brown as part of her investigation: Jon Edon;[372] Sarah Williams;[373] Jordan Rowley;[374] Neha Walia;[375] Vicky Moore;[376] and Henry Hutton-Mawdsley.[377] These were not individuals with axes to grind (in either direction), and while, understandably, the accounts are not identical, broad, consistent themes emerge. Moreover, these interviews – particularly those of Ms Moore and Mr Hutton-Mawdsley – demonstrate that staff were willing to give a true and accurate

[368] CJS005888_0004

[369] CJS001594_0012

[370] CJS001594_0013

[371] CJS001594_0013

[372] CJS005869

[373] CJS005870

[374] CJS005881

[375] CJS005884

[376] CJS005889

[377] CJS005894

account of events when incidents were investigated, even where doing so entailed providing information that showed colleagues in a poor light and could lead to adverse consequences for them. Indeed, in taking the decision to find the allegations proved and determining to dismiss DCO Fagbo, Steve Skitt expressly relied upon (amongst other things) evidence from "*an[other] officer*".[378] This case does not shed light on a culture of officers being unwilling to 'snitch' or 'grass' on their colleagues. On the contrary, their willingness to give an honest account contributed to their colleagues' dismissal for gross misconduct.

316. Taking the two incidents in turn: first that involving DCO Fagbo, and then that concerning DCO Munroe.

317. It is important to recognise that there is some context to the friction between DCO Fagbo and D119 on 21 April 2017. As the SIR[379] submitted by DCO Fagbo points out, earlier that day (before the incident with which the Inquiry is concerned), DCO Fagbo alleges that he had been "*cornered*" by D119, who had claimed that DCO Fagbo was the reason that D119 was on closed visits, calling DCO Fagbo a "*snake*", a "*coconut*" (a racial epithet for a black person, alleging that they are 'white on the inside') and a "*sell out*". That SIR was completed at 09:10 on 22 April 2017, seemingly before any complaints were made against DCO Fagbo (and before he would have been made aware of them).[380] It was not thus not responsive to a complaint in a manner that would undermine its credibility.

318. Clearly, then, by the evening of 21 April 2017, there was already some friction between D119 and DCO Fagbo, with D119 seemingly holding DCO Fagbo to blame for the limitations on his visits. Indeed, both D119 and DCO Fagbo have, in their various accounts conceded aspects of what occurred, from which a consensus can be drawn, utilising the accounts of others. The core allegation against DCO Fagbo was that he called D119 a "*fucking dickhead*".[381] While DCO Fagbo has made the point that he did not grow up around such language, and so did not recall using such language[382], he ultimately accepted in both his written statement[383] and in oral evidence[384] that he *may* have said "*you're the fuck [sic]*

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[378] CJS0072930_0001

[379] CJS005280_0002

[380] Babatunde Fagbo 4 March 2021 92/1-4

[381] CJS005880_0001; CJS005894_0003.

[382] BFA000001_0009, para 36

[383] BFA000001_0004, para 13

[384] Babatunde Fagbo 4 March 2021 94/1-3

dickhead" *in response* to D119. In his first witness statement at paragraph 26, DCO Fagbo appears to take issue with whether he would have used the word "*fucking*" (before 'dickhead').[385] In fairness to DCO Fagbo, it should be noted that Henry Hutton-Mawdsley, when asked what DCO Fagbo had said, told Michelle Brown: "*So Babs and D119 were screaming at each other, but I cant recall the words, I think "you fucking dickhead"…* ".[386] Similarly, both D119[387] and D720[388] in their interviews with Michelle Brown referred to DCO Fagbo using the language "*dickhead*", but not "*fucking dickhead*". That point is made out of fairness to DCO Fagbo, and G4S does not suggest that much turns on whether the language used was "*dickhead*" or "*fucking dickhead*" (although the latter is more coarse).

319. In light of the information contained in the interviews of Henry Hutton-Mawdsley and Vicky Moore, in particular, both independent observers (and G4S staff), both of whom recall DCO Fagbo call D119 a "*fucking dickhead*", G4S considers it likely that DCO Fagbo did use such language – either with or without the initial expletive – towards D119, conduct which the Company considers (and considered at the time) to be unacceptable towards a detained person in its care. Similarly, DCO Fagbo's account is that he did not patronisingly refer to his ability to go home to his family (unlike D119), but rather that when D119 said to him "*what are you fucking rushing home for anyways?*" his response was "*that I am contracted to work 13 hours and after the contractual hour, I am entitled to go home to see my family*".[389] G4S suggests that this is suggestive of an *ex post facto* justification, particularly in light of evidence from independent bystanders to the effect that as D119 was going into his room, DCO Fagbo waved towards him and said "*bye bye*" in a patronising manner.[390]

320. There were certain factors that the Inquiry might consider 'mitigatory' towards DCO Fagbo:

    (a) Even before the incident, D119 appears to have maintained hostilities towards DCO Fagbo, and may have used racialised language towards him (see above). D119 accepted that even before this incident "*I have had little moments before with him*".[391]

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[385] BFA000001_0007, para 26

[386] CJS005894_0003

[387] CJS005880

[388] CJS005874

[389] BFA000001_0004, para 13

[390] CJS005889_0003

[391] CJS005880_0001

Further, the suggestion that D119 saw DCO Fagbo as a 'traitor' is corroborated by the account of Neha Walia.[392]

(b) D119 accepts that he also called DCO Fagbo a "*dickhead*";[393] and there is evidence that D119 was swearing.[394]

(c) The contemporaneous evidence suggests that both DCO Fagbo and D119 were being verbally aggressive towards each other.[395]

(d) The incident occurred in the (frustrating) context of D119 refusing to go into his room during lock-up;[396] with D119 "*acting like a child*".[397]

321. G4S, while being realistic as to how detained persons can, in some circumstances, act in a manner provocative towards staff, nevertheless expects its staff to maintain professionalism at all times. Even if staff are being verbally goaded by a detained person, they are ultimately in a position of authority and responsibility and are expected to maintain dignity and professionalism at all times. In reaching a finding on DCO Fagbo's disciplinary, Steve Skitt recognised that D119 could be a "*challenging individual and has been involved in a number of concerns within the centre*".[398] Nevertheless, in spite of that Steve Skitt concluded that DCO Fagbo had used "*inappropriate and offensive language*" (as had D119); he failed to step back and de-escalate the situation when he could have done; and was "*patronising both verbally and physically towards D119 by waving to him and stating words to the effect of 'going home to see your kids' and saying 'bye bye'*".[399]

322. Steve Skitt's conclusion was that DCO Fagbo's conduct was not the "*expected behaviour of a professional officer*" and also "*goes against… our values as an organisation in acting with integrity and care…These actions have taken place are in conflict with… company values*

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[392] CJS005884_0002

[393] CJS005880_0001; see also CJS005889_0001

[394] CJS005881_0002

[395] CJS005869_0001; CJS005870_0001; CJS005884_0003; CJS005894_0002

[396] CJS005869_0001; CJS005881_0001

[397] CJS005870_0001

[398] CJS0072900_0001. See also the SIR of 22 April 2017 which records D119 as having been associated with "*damage to property, 2 assaulting custody officer, 1 ABH… violent disorder, racially threatening abusive words…*": CJS005280_0003.

[399] CJS0072900_0001-0002.

and they are behaviours that are not accepted or tolerated within our organisation".[400] This constituted gross misconduct and Steve Skitt's decision was that DCO Fagbo would be dismissed effective 16 August 2017 (the date of the reconstituted dismissal hearing).[401]

323. There is little for G4S to add at this stage to the conclusions and findings of Steve Skitt, which it stands by and maintains. That very fact demonstrates the robustness of the Company's disciplinary processes when complaints were brought to its attention. Notably, the decision to summarily dismiss DCO Fagbo took place on 16 August 2017, over two weeks *before* Panorama. This was not a knee-jerk response to Panorama; it was a fair reflection of the Company's attitude and approach to its staff acting unprofessionally, even where there was arguably provocative or challenging conduct by a detained person.

324. There are notable parallels between the incident between D119 and DCO Fagbo and that between D119 and DCO Munroe the next day (22 April 2017). In relation to the latter, the broad outlines of the incident emerge consistently from the evidence: chiefly the accounts of D119;[402] and Henry Hutton-Mawdsley[403] (both given to Michelle Brown as part of her investigation); as well as the witness evidence of Ms Munroe (both in writing[404] and orally[405]). The main discrepancies relate to the particular words used and some of the finer details, rather than the broader 'headlines' of the incident.

325. Again, as in relation to the incident between D119 and DCO Fagbo, there was something hinterland to the incident, with D119 and DCO Munroe having had "*an exchange of words*" a few days prior to the incident.[406] That incident provides some useful context to appreciate the heightened tensions between D119 and DCO Munroe in the run-up to the incident. In relation to the trigger for the incident, itself, D119's account is that he had heard DCO Munroe saying to DCO Will Fagbo (DCO Babatunde Fagbo's son): "*that prick over there had an argument with your Dad*".[407] Henry Hutton-Mawdsley in his interview with Michelle Brown was certainly not unwilling to provide information that showed colleagues in a

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[400] CJS0072900_0002

[401] CJS0072930.

[402] CJS005880

[403] CJS005894

[404] INN000013_0025ff

[405] Shayne Munroe 4 March 2021 45/19-53/8.

[406] INN000013_0024, para 76; CJS005894_0001

[407] CJS005880_0002

negative light (as demonstrated above). However, he did not recall DCO Munroe having said the words attributed to her by D119.[408] Rather, his evidence is that D119's "*anger was aimed at [DCO Munroe] as he thought it was [DCO Munroe] talking about him to Will [Fagbo]*".[409] DCO Munroe fervently denies having said this to Will Fagbo, and her position is a credible one: "*I couldn't have told him that because I wasn't there the day before, so I wouldn't have known*".[410] It is also consistent with Henry Hutton-Mawdsley suggesting that it was in fact he who was speaking to Will Fagbo about the previous night.[411] Moreover, in light of the fact that D119 was in the servery while DCO Munroe was in the office with Henry Hutton-Mawdsley and Will Fagbo,[412] it is suggested that D119 was likely not in a position to have heard who exactly said what to whom. His own account was primarily that as he was getting breakfast, he "*heard a female voice*" make the offending comments.[413] It seems, therefore, that the incident was triggered by the fact that – as Henry Hutton-Mawdsley observed (see above) – D119 *thought* DCO Munroe was talking about him to Will Fagbo.[414] However, as explained above, there are real doubts as to whether she did in fact do so.

326. Nevertheless, at that point, it is essentially common ground that the incident escalated as between D119 and DCO Munroe. DCO Munroe contends that D119 began by hurling abuse at her and waving his hands in her face, to which her reaction was then defensive.[415] It is common ground as between D119 and DCO Munroe that he asked her to 'swear on her son's life' that she had not been talking about him; that DCO Munroe did so; and so D119 said to her as a result that her son would now die (because he suggested that she had lied).[416] Further, D119 accepts that he told DCO Munroe that she was a "*bitch*", called her fat, and that he told her to "*suck your mum back*" in a raised voice (although in relation to the latter

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[408] CJS005894_0005

[409] CJS005894_0003

[410] Shayne Munroe 4 March 2021 47/20-21.

[411] CJS005894_0004

[412] CJS005894_0003

[413] CJS005880_0002

[414] See also INN000013_0025, para 78

[415] INN000013_0025, para 78; Shayne Munroe 4 March 2021 48/4-14

[416] CJS005880_0003; INN000013_0025, para 78.

he contends that this was in response to DCO Munroe proffering the same insult to him.[417] D119 also observed that after the incident DCO Munroe was in tears to DCM Phil Page.[418]

327. In terms of DCO Munroe's own conduct, her evidence is that once D119 had told her that her child would die (as a result of her having sworn on her child's life), she was angry and so said something along the lines of 'fuck you', 'fuck off' or 'shut the fuck up'.[419] She was frustrated that Henry Hutton-Mawdsley and Will Fagbo had not intervened and so she explained that she thinks she called Henry Hutton-Mawdsley a 'dickhead' as a result.[420] For his part, Henry Hutton-Mawdsley accepts this: "*[DCO Munroe] was in tears and asking why you didn't back me up. In hindsight I should have done more.*"[421] However, he also explains that: both D119 and DCO Munroe were screaming at each other and "*acting like kids*", both were swearing; DCO Munroe may have called D119 "*a fucking dickhead*"; and they had both told each other to "*go suck your mum*".[422]

328. Steve Skitt was the manager determining the outcome of DCO Munroe's disciplinary hearing. As in the case of DCO Fagbo, he recognised that D119 was a challenging individual and that both parties were using "*inappropriate and offensive language towards each other*".[423] The nub of his conclusions – which G4S stands by – was that:

> "I find the behaviour that you displayed on that morning goes against our conduct procedures and our values as an organisation in acting with integrity and care. I would expect all staff that work within our centres to act professionally and with integrity and all our interactions with detainees. I am aware that on occasions we can become frustrated and angry but the fact is we must at all times act in a professional manner and to do otherwise is to put ourselves and our colleagues and our organisation at risk. I'm absolutely clear my expectation is that we never act inappropriately towards those in our care or towards each other even when we are provoked with poor behaviour that can be displayed from certain disruptive individuals in our care. We have procedures and protocols that are available to assist in dealing with poor behaviour that is displayed by them on occasions"[424] (emphasis added).

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[417] CJS005880_0003

[418] CJS005880_0003

[419] INN000013_0026, para 78; Shayne Munroe 4 March 2021 48/20-23

[420] INN000013_0026, para 79

[421] CJS005894_0004

[422] CJS005894_0003-0004

[423] CJS005896_0001-0002.

[424] CJS005896_0002.

329. DCO Munroe was summarily dismissed for gross misconduct as a result of this incident. Again, as in the case of DCO Fagbo, this was G4S clearly recognising that even where staff unprofessionalism was in response to or provoked by disruption by detained persons, there was simply no excuse for any poor behaviour by staff – which would led to summary dismissal. That is evidently the case here where DCO Munroe's conduct, on the evidence, appears to extend [only] to raising her voice, swearing and possibly using an offensive phrase ('suck your mum'); in circumstances where she was understandably upset by D119 having suggested that her child would die and shouting and swearing at her, too. Nevertheless, in G4S' eyes that still sufficed to warrant DCO Munroe's summary dismissal, such is the Company's attitude to those staff members acting disrespectfully to those individuals in their care. It is plainly not right that the outcome of DCO Munroe's disciplinary hearing was impacted (at all, let alone 'significantly') by Panorama, as she suggests.[425] That is evident given the similarity of the fact pattern between the complaints made by D119 and D720 against DCOs Fagbo and Munroe (and the shared investigation of them both) – and the fact that DCO Fagbo was dismissed well before Panorama aired. DCO Munroe's dismissal was of a piece with the pre-Panorama dismissal of DCO Fagbo: similar incidents, where the Company took a zero tolerance approach to the use by its staff of inappropriate language and attitude towards detained persons.

330. Both these cases demonstrate a particularly strict approach by the Company to stamping out any display of poor attitude by its staff towards detained persons – which, it is suggested, should be commended by the Inquiry. Neither of the underlying incidents can reasonably be said to have come close to engaging Article 3; yet the Company still took the view that it should summarily dismiss the staff member concerned. That neither case comes near to Article 3 is made plain by the fact that both cases involve a 'challenging' detainee, whose own conduct certainly contributed to the incident, if not provoked it. In such circumstances, one-off usage of bad language or patronising gestures fall far short of the high bar set by Article 3 of the Convention.

Rows 9-11, 13-15: Incidents involving D1527 on 24-25 April and 4 May 2017

[425] Shayne Munroe 4 March 2021 55/5-17. Nor is there any basis at all to suggest that the dismissals of either DCO Fagbo or Munroe had anything to do with their race.

331. G4S considers these three sets of incidents together, as the PSU did;[426] and because D1527's submissions on Article 3 are made on the basis that the incidents are not to be assessed on an isolated basis.[427] G4S accepts that submission up to a point. It is right that the Article 3 analysis does not necessary look at individual incidents in a siloed nature, oblivious to the wider history and context. In the words of D1527's submissions, there should be no "*artificial dislocation*" of incidents. However, it is also true the question is whether particular identifiable conduct violated Article 3. A feature of one incident cannot make up for what is lacking about another – particularly if those incidents are not directly related to one another. Putting the point practically, the effect of the course of incidents over the evening of 25 April 2017 are much more likely to have a bearing on one another (e.g. in relation to D1527's mental state at the time) than, for example, the incident on 4 May, occurring over a week later. D1527 cannot permissibly piece together an Article 3 'jigsaw' by cherry-picking particular aspects of different incidents because none satisfy the criteria on their own (e.g. the alleged intent behind conduct in one incident; with the mental effect or duration of another). Those points will come into relief as the particular incidents are considered below.

24 April (Rows 9-10, 14-15)

332. This incident occurred on E wing on 24 April 2017, to which D1527 had been brought from C wing the previous evening, owing to having self-harmed. D1527 told Callum Tulley and another officer that he had self-harmed the previous night because he was in detention.[428] He refused to communicate with healthcare staff on the morning on 24 April.[429] In the course of his ACDT review on 24 April 2017, D1527 told Nathan Ring that he wished to return to his old room on C wing. Nathan Ring informed him that a decision regarding his relocation would take place after the ACDT review. However, to assist D1527, Nathan Ring telephoned C wing to enquire about his old room and property. He was informed by C wing staff that someone else had already moved into that room.[430] It appears from the undercover footage that D1527 was upset that someone else had moved into his old room before his

[426] CJS001107

[427] Closing Statements 5 April 2022 56/24-57/6

[428] TRN0000035_0019

[429] HOM000152

[430] HOM000152

property had been cleared up: he was "*afraid someone is going to like take his stuff and like*".[431] There is no suggestion that there was any malice or intent behind moving someone else into D1527's old room without having cleared out his property. It is described by a staff member on the undercover footage as "*just a misunderstanding*"; or seemingly an inadvertent mistake, referring to the C wing staff as "*idiots… didn't do a room clearance*".[432]

333. It appears that this is the trigger for a further self-harm attempt by D1527 on E wing. As the ACDT review document shows: "*When informed D1527 of [the fact he could not return to his previous room] he returned to his room and began to throw his chair at the door. I asked the officers on the unit to keep an eye on him, and only a few moments later I was alerted that D1527 had now ripped up one of his sheets and wrapped it around his neck*".[433]

334. As a result of this, force was used to remove the ligature: use of force event 104/17. his is also reflected in the observations record for 24 April – showing that D1527 was informed that he would not be returning to his old room at 15:15, and attempted to tie a ligature around his neck (which was removed) at 15:20.[434]

335. The use of force to remove the ligature has been assessed by Mr Collier.[435] G4S invites the Inquiry to accept his evidence that:[436]

> "519 In this circumstance staff are lawfully authorised to use for force to prevent self-harm. The necessity to preserve life is paramount and all efforts should be made to verbally gain compliance unless immediate action is required (see Detention Centre Rules 2001, Rule43 (1)).
>
> 520. Based on the staff statements it appears as a reaction to seeing the ligature DCO Croucher controlled the right arm of D1527 in order to allow the ligature to be removed. DCM Brown assisted by holding the legs of D1527 to prevent him kicking out and putting staff at risk of harm, or to prevent the removal of the ligature."

336. Overall, Mr Collier was "*satisfied that the force used was necessary and proportionate to the risk at the time*".[437] This is consistent with the UoF reports filed;[438] as well as Nathan

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[431] TRN0000035_0019

[432] TRN0000035_0018

[433] HOM000152

[434] CJS001085_0002

[435] INQ000111_0123-0124, paras 518-524; also INQ000177_0011, paras 45-46

[436] INQ000111_0123

[437] INQ000111_0124, para 524

[438] CJS005538

Ring's Incident Report.[439] Healthcare were called; but D1527 refused to permit the medical staff to assess him.[440]

337. There is – or should be – little controversial surrounding the use of force on this occasion, necessary as it was to release D1527 from the ligature. Indeed, D1527 himself does not appear to make any complaint about it in his witness statement to the Inquiry;[441] and it is mentioned, but not in the context of any criticism, in the wide-ranging PSU investigation report into the treatment of D1527 revealed by Panorama.[442]

338. The observation notes also record that shortly after the incident – given that it was seemingly triggered by D1527's inability to return to his previous room: "*Officer trying to talk to D1527 about how he is feeling and trying to get him to change rooms*".[443]

339. The second aspect to the events of 24 April 2017 relate to comments made by DCO Kalvin Sanders on 4 and 8 May 2017 whilst being recorded undercover by Callum Tulley. In the course of those conversations, the transcript records:

(a) Kalvin Sanders:

(i) Saying that he was on constant watch duty for D1527 [on 24 April], that D1527 was being a "*right prick*" and was trying to press his index finger into the side of his neck, so he [Kalvin Sanders] squeezed his hand around D1527's index finger.[444]

(ii) Saying that as D1527 was banging his head on the table, he [Kalvin Sanders] "*held it right there*" (slamming his hand down, as if he was pushing it on D1527's head); and as D1527 was trying to push his finger into his neck, Kalvin Sanders grabbed D1527's finger and thumb, squeezed them together and said "*told you I stop you doing it*".[445]

(b) Aaron Stokes saying, in response to Callum Tulley asking what the best way is to deal with D1527: "*turn away and hope he's swinging, probably*"; as well as saying to

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[439] HOM000784

[440] CJS005538_0014-0015; see also CJS001085_0002 (entry at 15:32)

[441] DL0000144_0018

[442] CJS001107; see the references at CJS001107_0021, para 7.28 and CJS001107_0050

[443] CJS001085_0002 (first entry at 15:40)

[444] TRN0000096_0002

[445] TRN0000097_0002

Kalvin Sanders: "*did you not have the urge to just punch [D1527] I his face as he's gone up and 'bang*"'.[446]

340. The video footage records what Kalvin Sanders and Aaron Stokes said. Aaron Stokes' only explanation for his comments was that: "*I believe I must [have] really only been blowing off steam amongst colleagues, trying to laugh off having a bad day between fellow DCOs and didn't mean anything by it or cause any upset to anyone*".[447] In his oral evidence he explained that "*if I truly believed in [sic] that time that there was someone in danger, I would have stood up and done the right thing and then reported it accordingly. But, as I said in my statement, I believed it nothing more than just comments made between officers, just letting off steam during the day*".[448] Additionally, in his oral evidence he apologised if he had caused any upset or insensitivity by what he had said.[449]

341. The key question for the Inquiry is whether what Kalvin Sanders said on 4 and 8 May reflects what he actually did on 24 April; or whether he was fabricated or exaggerating in front of other officers.

342. The observations log records Kalvin Sanders has taking over the constant observations of D1527 at 15:40 on 24 April 2017.[450] He records as follows:[451]

> "15:52 D1527 was banging his head on the base of his bed repeatedly. I went in to prevent him doing any further damage.
>
> 16:03 D1527 is trying to drive his index [finger] either side of his neck with extreme pressure. I have asked him to stop or I will place my hands on his hands to pull them away to prevent him injuring himself.
>
> 16:16 D1527 keeps banging his head on the base of his bed. I am trying to talk him out of it and to sit up and talk to me so I can try and help.
>
> ..
> 16:47 D1527 has engage [sic] in conversation and is now talking to me – wishes to go to the mosque"

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[446] TRN0000096_0002

[447] INQ000132_0005, para 11(b)

[448] Aaron Stokes 9 March 2022 191/23-192/3

[449] Aaron Stokes 9 March 2022 193/11-15

[450] CJS001085_0003 (second 15:40 entry)

[451] CJS001085_0003

343. As a starting point then, the documentary evidence shows that Kalvin Sanders was on constant watch duties – and entered D1527's room – when he subsequently told officers he held D1527's head on the table and squeezed his fingers together.

344. However, his evidence both to his Inquiry and the PSU was that in fact he "*tried to help D1527 rather than hurt him*"[452] and "*I would never hurt him. You know, I made out – I sort of did what I did to my – to the colleagues, you know, to try and fit in. But that was – the only reason that story was made up, you know, was to try and fit in*".[453]

345. The PSU concluded that this allegation was 'on balance' substantiated. It did so in the following terms:[454]

> "Whilst there is no proof DCO Sanders hurt D1527, the extent of DCO Sanders descriptions and his willingness to talk about what he had done, suggested that on balance, it was more likely than not to have occurred, and that DCO Sanders did hurt D1527 as he stated. Therefore the allegation is substantiated."

346. The position taken by G4S was slightly more nuanced. It summarily dismissed Kalvin Sanders because his comments to colleagues were unacceptable. In relation to the underlying conduct, this could be neither proved nor disproved:[455]

> "While you have since informed me that you did not actually carry out the actions, I have two versions of events from you and no evidence to prove or disprove whether this occurred.
>
> Whether you have carried out the assaults or not I do not expect any member of staff to behave in this way, which is to glorify violence to colleagues and brag about assaulting a detainee."

347. The question of whether Kalvin Sanders did, in fact, carry out this conduct is not easy one for the Inquiry to answer. It should be noted that D1527's own evidence is: "*I do not remember much about this incident to confirm any details about this*".[456] If Kalvin Sanders had, in fact, banged D1527's head on the table or assaulted him, the Chair may well expect D1527 to have recalled that – or at least some part of the incident.

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[452] CJS001107_0019, para 7.15

[453] Kalvin Sanders 4 March 2022 131/1-5

[454] CJS001107_0020, para 7.20

[455] HOM001297_0002

[456] DL0000244_0010, para 35

348. G4S therefore submits that the truth may lie somewhere between what Kalvin Sanders told his colleagues on 4 and 8 May and the suggestion that they were completely fabricated. For example, the observation log records D1527 banging his head on the base of his bed – while in the footage Kalvin Sanders refers to D1527 banging it on the table.[457] This, in fact, supports what Kalvin Sanders said in oral evidence – namely that: "*You know, in the moments I said I was banging his head down, in reality, I was actually placing a pillow under his head to stop him hurting it, you know?*".[458] That is consistent with the contemporaneous logs given the reference to pillow suggests that the banging was on the bed base, not the table. By contrast, the comments made on 8 May that Kalvin Sanders said "*told you I stop you doing it*" as he grabbed or squeezed D1527's fingers as D1527 sought to press them into his neck is consistent with the observation log, which records that Kalvin Sanders told D1527: "*I have asked him to stop or I will place my hands on his hands to pull them away to prevent him injuring himself*". What he described to colleagues may well have been him doing precisely that. It is not necessarily the case, though, that this action was one of assault, even if it occurred. In circumstances in which D1527 was pressing his fingers into his neck, Kalvin Sanders would have been entitled to use reasonable force to prevent him from doing so, to prevent harm to D1527.

349. In the circumstances, G4S submits that the Inquiry cannot be certain that Kalvin Sanders assaulted D1527, nor can it be satisfied so on the balance of probabilities – even before addressing the difficult question of precisely *what* Kalvin Sanders did, regardless of the appropriate standard of proof. What can be said – as G4S did when dismissed Kalvin Sanders – is that it is beyond doubt that Kalvin Sanders used language glorifying violence to colleagues, which is wholly unacceptable.

25 April (Row 11)

350. This incident is the one by Mr Collier as "*the most concerning case based on the potential risk*"[459] and "*the most distressing treatment*" that Callum Tulley reported to have seen.[460] G4S does not demur from those as descriptions of the conduct of Yan Paschali to D1527.

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[457] TRN0000096_0002; TRN0000097_0002

[458] Kalvin Sanders 4 March 2022 129/18-21

[459] INQ000111_0020, para 52

[460] CJS001107_0054

That conduct was abhorrent, unacceptable and – as explained below – G4S does not accept Mr Paschali's purported justification for his actions, given after the fact.

351. The incident itself can be broken down into three parts (although the first two could be considered a slightly broader, single incident):

(a) First, an incident that occurred at approximately 19:09 in which DCM Steve Loughton used a fish knife to remove a ligature from the neck of D1527. This has been recorded as UoF incident 105/17.

(b) Shortly thereafter, D1527 was seen (or at least believed) to have a phone battery in his mouth – which was then disposed of.

(c) Thirdly, at approximately 19:33 Callum Tulley (who is in D1527's room with Clayton Fraser) sees D1527 trying to self-strangulate and calls for help: Nurse Jo Buss, Yan Paschali and Charlie Francis enter. D1527 is restrained on the floor and Yan Paschali has his hands on D1527's neck, telling him: "*don't fucking move you piece of shit… I'm going to put you to fucking sleep*".

352. The Inquiry may also be assisted in the chronology by the timeline appended to the PSU report into conduct in relation to D1527 for 25 April 2017.[461] It also has a substantial amount of undercover video footage (as well as CCTV).[462]

353. Taking those stages in turn (the final one being the most important and concerning aspect):

354. The first element – namely Steve Loughton's removal of a ligature from D1527's neck was subject to a UoF report at the time, authored by Steve Loughton.[463] In it he describes checking on the daily food refusals and:[464]

> "I was told by the officer who was watching [D1527] DCO Fraser that he had just gone into the toilet area and he couldn't see him properly, I entered the room and called his name but had no answer, I then went into the toilet area which is where I saw D1527 curled up around the toilet area with what looked like a ripped t-shirt around his neck which he was holding onto. I attempted to loose the ligature but D1527 was holding onto it so I asked DCO Fraser to pass me his fish knife and I managed to cut the ligature off, I then pulled D1527 out of the toilet area and asked him to sit on the bed which he did and I called for medical assistance on my radio."

[461] CJS001107_0052

[462] The key clips are KENCOV1007: V2017042500020; V2017042500021

[463] CJS005534

[464] CJS005534_0008

355. D1527's own account of the incident does not entail any criticism of staff. He says in his Inquiry witness statement (quoting his earlier witness statement prepared for judicial review proceedings):[465]

> "39. The next day, which I believe to have been 25 April 2017, I cut my t-shirt and tied this around my neck. An officer came to stop me, and cut the t-shirt with a knife or something similar. I was choking, and I don't remember everything that happened. When this happened, 1 was having a flashback, and I'm not thinking or noticing what the people around me are saying or doing. I see myself somewhere else, back in Egypt, and I don't remember properly what is going on at the time, because I feel like I am somewhere else. I remember people swearing at me, but not about what.
>
> 40. After they removed the t-shirt from my neck, I was placed forcefully on the floor of the cell, in the middle of the room. I was on the floor for a few minutes, I am not sure exactly how long."

356. Mr Collier's observations on this part of the incident (i.e. that constituting UoF 105/17 involving the removal of the ligature) are also positive. He states that: "*The initial actions of DCM Loughton when he identified the act of self-harm and took immediate action should be acknowledged*;[466] "*the initial actions of DCM Loughton are commendable*";[467] and "*the action to cut the ligature was correct and the only action available*".[468]

357. The UoF form for the incident records that Steve Loughton entered D1527's room because he was told by "*the officer watching him DCO Fraser that he had just gone into the toilet area and he couldn't see him properly*".[469] Steve Loughton's evidence is that Clayton Fraser was on constant watch duty and should not have lost sight of D1527; certainly not to the point where D1527 was able to place a ligature around his neck.[470] He amplified this in oral evidence, suggesting that Clayton Fraser should have entered the room earlier.[471] Clayton Fraser's evidence, by contrast was that:[472]

> "I was probably going over my notes and, when I looked up, I noticed he was not on his bed so I looked up in the mirror and there he was in the

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[465] DL00002144_0018-19, para 49

[466] INQ000111_0016, para 35

[467] INQ000111_0018, para 40

[468] INQ000111_0019, para 48

[469] CJS00534_0008

[470] SER000447_0019, para 85

[471] Steve Loughton 1 March 2022 98/8-9

[472] Clayton Fraser 28 February 2022 48/24-49/14

> bathroom, and so, when I looked carefully, I saw he had the material around his neck…I called for assistance as soon as I saw the irregular routines".

358. G4S submits that Steve Loughton's account is to be preferred. By his own admission, Clayton Fraser's recollection of events and their chronology is not strong: "*I can't remember the exact events, the exact way it happened, the exact events*".[473] The most contemporaneous account is that in the UoF report, which suggests that Clayton Fraser could not see D1527 properly (i.e. from outside the room) and so called for assistance from Steve Loughton – who entered the room. There is no suggestion in that report that Steve Loughton was called because Clayton Fraser had seen the ligature. In the circumstances, if D1527 had moved into a position where he could not be seen, Clayton Fraser as the officer on observation duty should have moved immediately into a position from which he could observe D1527, entering the room if necessary. That should not have required assistance from a DCM; and the fact that D1527 had already been able to tie a ligature suggests that Clayton Fraser should have taken action earlier or swifter to maintain a watch on him.

359. Overall, however, this aspect of the wider incident was resolved swiftly, with minimal, but appropriate force in the form of Steve Loughton's removal of the ligature.

360. The second aspect of the incident concerns the battery that was in, or at the very least perceived to be in, D1527's mouth. On this particular aspect, in particular: whether the battery entered D1527's mouth; and, if it did, when and how it was removed – the evidence is unclear. For example:

    (a) In the footage, shortly after DCM Loughton removes the ligature from D1527 and he sits on the bed, officers appear to notice a battery in his mouth.[474] There are then various references to "*he's got a battery. Give me the battery*"; "*don't put it in your mouth*"; "*he's got a battery in his mouth*"; "*he tried to swallow a battery*"; "*don't swallow it*"; "*take the battery out of your mouth*" etc.[475] Certainly the perception, at the very least, was that D1527 had put a battery in his mouth.

    (b) D1527's own evidence is that "*after they removed the t-shirt from my neck…I sat on the bed in the cell. I took the battery out of my phone and put it in my mouth. I don't*

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[473] Clayton Fraser 28 February 2022 53/13-14 (also 48/6-11)

[474] TRN0000001_0001-0002

[475] TRN0000001_0002-0005

remember much about putting the battery in my mouth, but I remember it being taken out by force. I did not take it out myself".[476]

(c) The suggestion that D1527 never actually put the battery in his mouth comes from the video transcript in which Nathan Ring is recorded as saying: "*He ain't got a battery in his mouth had he – nah I said to you it's all good... he put the battery round his mouth and pretended to chew it up, and when I checked it, it was all in the drain. He picked it up, put it round his face and [inaudible] chucked it all down the drain to look like he'd, like he'd [inaudible] the toilet*".[477]

361. G4S submits that, on the balance of probabilities D1527 did put a battery in his mouth. That is his own, clear evidence – which G4S invites the Inquiry to accept. Further, a number of staff nearby all witnessed the incident and considered D1527 to have put the battery in his mouth, including Steve Loughton[478] and Callum Tulley.[479] The latter was clear about this in his oral evidence.[480]

362. The evidence is particularly unclear as to how the battery came out of D1527's mouth. As noted above, D1527 suggests it was taken out forcibly (but does not say when). G4S suggests that the most likely position is that it came out (however so), fairly soon after D1527 had put it in, and before Steve Loughton left the scene. As Steve Loughton observes – it is suggested rightly – he would not have left the scene (certainly as the DCM present) if the battery was still in D1527's mouth.[481] Callum Tulley could not recall in his statement to Sussex Police when it was removed: "*I am unsure at what point the battery was removed from D1527's mouth... I assume that... the battery was removed from his mouth to ensure he did not try to swallow it again*".[482] In his oral evidence Mr Tulley was asked:[483]

> "Q. But he must have released it at some point?
> A. Yes, sir, oh, definitely.
> Q. So the battery part of the incident, how long did that last for, roughly?
> A. Five minutes.
> Q. Yes?

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[476] DL0000144_0019

[477] TRN0000001_0002-0011; see also Nathan Ring 25 February 2022 86/7-11

[478] SER000447_0015, para 70

[479] INQ000051_0038, para 23

[480] Callum Tulley 1 December 2021 100/8-12; 101/15-19

[481] SER000447_0015, para 70

[482] SXP000120_0005

[483] Callum Tulley 1 December 2021 101/20-102/1

A. Five to ten minutes."

363. That language suggests that D1527 gave up the battery, rather than having it forcibly removed. It is also mirrored by Charlie Francis asking Callum Tulley if D1527 had "*give[n] the battery up*" to which Mr Tulley's response was "*I didn't see it happen, but I believe he has done, yeah, because he's chatting away in there, so*".[484] Furthermore, Jo Buss' notes on D1527's medical records state: "*put mobile phone battery in his mouth which he later removed*".[485]

364. G4S submits that on the balance of probabilities D1527 gave up the battery, rather than having it forcibly removed by a member of staff. Had the latter occurred, one would have expected some form of evidence suggestive of this – whether witness evidence; a reference in the UoF report, or something captured by the undercover recording, even suggestive of a forced removal of the battery – but there is none. Moreover, the medical records say in terms that D1527 removed the battery. In any event, though, it is submitted that little turns on this. Even if the battery was forcibly removed, staff would have had a justification for doing so – clearly the continued presence of the battery in D1527's presented a substantial risk to his health; and attempts had been made for him to release it by persuasion.[486]

365. Approximately 20 minutes after the first incident (19:33), Callum Tulley takes over the constant observation of D1527 from Nathan Ring. Shortly thereafter, Callum Tulley witnesses D1527 attempting to self-strangulate, as is recorded in the undercover footage.[487] He calls for assistance and then describes an initial use of force by him, Clayton Fraser and Charlie Francis to prevent D1527 harming himself:[488]

> "245. The force I was using on D1527 was reasonable in the circumstances. He was using his hands to self-strangulate, so it was reasonable for me to try to pull his arms and hands away from his neck. After Clayton Fraser and Charlie Francis arrived following my call for help, I managed to gain control of one arm, Charlie control of another, and Clayton control of the legs. The three of us managed to prevent a detainee from self-harming, which was imperative at that time, given D1527 vulnerable state and his previous attempts to harm himself.

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[484] TRN0000001_0015

[485] CJS0010002_0038

[486] See INQ000111_0015, para 34(ii); and notwithstanding what is said at para 7.44 of the PSU report, suggesting that it would be an "*inappropriate use of force*" to remove the battery: CJS001107_0023

[487] KENCOV1007: V2017042500021

[488] INQ000052_0065

> 246. Once we had successfully prevented D1527 from self-harming further, he was laying on his back. I remained in control of his left arm, Charlie in control of his right, and Clayton in control of his legs. I was able to relax my grip on D1527's arm as he began to calm down, ensuring the use of force I was applying during the restraint remained proportionate and reasonable in the circumstances. Yan then joined the restraint."

366. Callum Tulley broadly echoed this evidence orally.[489] The Chair might get the impression from that evidence that Mr Tully, Clayton Fraser and Charlie Francis essentially had the situation under control – *after* which Yan Paschali joined in. However, considering of the footage, itself, demonstrates that is not the case. Callum Tulley makes his call for assistance at 07:22 on the footage time stamp; at 07:35 Yan Paschali is already present, while there is clearly a struggle taking place. The camera settles at approximately 07:50 (suggesting this is the point at which D1527 is under control). At that point D1527 is lying on his back and Yan Paschali is already participating in the restraint, with his knees either side of D1527's head.

367. At that point D1527 attempts to resist the restraint and Yan Paschali applies pressure to his neck. Callum Tulley's oral evidence was that Yan Paschali placed his fingers around D1527's neck and his thumbs on his Adam's apple: "*This clearly caused distress to D1527 and he began to resist*".[490] That is not quite consistent with the footage. At 07:50 Yan Paschali is shown with his hands around D1527's neck, and D1527 appears under the officers' control and not resisting; at approximately 08:07, Yan Paschali is shown to remove his hands from D1527's neck, and D1527 continues to be passive and seemingly under control. At 08:21 the officers say "*relax, relax*" to D1527, and he appears to begin resisting at approximately 08:22, immediately before Yan Paschali's hands return to D1527's neck.

368. Callum Tulley is right that in total Yan Paschali's hands were situated around D1527's throat for a longer period of time, but pressure was only applied for a short period – "*at least six seconds*".[491] This took place at 08:23 on the footage, seemingly following D1527's attempt to resist the restraint. It is during this period that Yan Paschali says to D1527: "*You fucking [inaudible], you fucking piece of shit because I'm going to put you to fucking sleep*".[492]

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[489] Callum Tulley 1 December 2021 104/20-106/22

[490] Callum Tulley 1 December 2021 106/19-22

[491] Callum Tulley 1 December 2021 107/20

[492] TRN0000002_0007

369. Callum Tulley's evidence is that he thought Yan Paschali would kill D1527.[493] It is right that Callum Tulley does say "*Yan, easy, easy*", although the suggestion that using this phrase might 'blow his cover'[494] seems somewhat hyperbolic or paranoid. On the contrary, while G4S accepts that Callum Tulley's words did suggest that he considered Yan Paschali to be going too far, the words chosen and their tone are not consistent with Callum Tulley genuinely believing, in the moment, that Yan Paschali was going to – or intended to – kill D1527 or cause him serious harm. The Inquiry is invited to reject that particular aspect of the evidence of Callum Tulley; although he clearly was concerned for D1527's wellbeing. Had he thought D1527's life was at risk, one would have expected a substantially stronger reaction – regardless of his journalistic cover.

370. Because the footage is, itself, relatively clear in what it shows,[495] G4S suggests that the key questions for the Inquiry are whether Yan Paschali applied pressure to D1527's throat; whether he genuinely believed at the time that there was or may have been a battery in D1527's mouth; and what Yan Paschali's intentions were in acting in this manner. It is the second of those questions which is likely to 'unlock' the others. That is because Yan Paschali's account is that he believed D1527 to have battery in his mouth;[496] and that accordingly he was bracing D1527's neck so that he could not swallow it.[497] In relation to what he said to D1527 ("*I'm going to put you to fucking sleep*"), Yan Paschali says this was a "*command*" given "*in order to gain compliance*";[498] and certainly not a threat.[499]

371. G4S invites the Inquiry not to accept Yan Paschali's evidence in this regard. It submits that he did not believe D1527 had a battery in his mouth at the time, and this has been given as an *ex post facto* justification of an unacceptable act of violence on a vulnerable person – for which there was no justification. It does so for the following reasons:

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[493] Callum Tulley 1 December 2021 108/12

[494] Callum Tulley 1 December 2021 108/16

[495] Having originally said that he was not sure whether he said "*I don't want to put you to fucking sleep*" or "*I will put you to fucking sleep*", Yan Paschali subsequently accepted having said: "*I'll put you to fucking sleep*": see Yan Paschali 24 February 2022 73/9-15; 81/6.

[496] See, e.g., Yan Paschali 24 February 2022 1119/19

[497] See, e.g., Yan Paschali 24 February 2022 83/17

[498] See, e.g., Yan Paschali 24 February 2022 88/20

[499] See, e.g., Yan Paschali 24 February 2022 92/11

(a) Yan Paschali's evidence in relation to the incident generally is to be treated with caution. There is no other material to suggest that it was he, rather than Steve Loughton, who cut the ligature from D1527's neck earlier, as Yan Paschali suggested.[500] On the contrary, Yan Paschali is wrong about this; and may well be wrong about other aspects of that evening. The PSU also concluded that he had been misleading in his evidence.[501]

(b) Whether correct or not – Nathan Ring had told Yan Paschali earlier that "*he aint got a battery in his mouth had he*".[502]

(c) The written transcript would appear to provide some support for Yan Paschali's account, when after he applied the alleged 'choke', he is ascribed as saying (after Charlie Francis asked: "*did he swallow the battery?*") "*in his mouth – where?*".[503] That would appear to support his contention because it would suggest that even after he applied the alleged choke, he believed the battery to be in D1527's mouth (which is why he would have answered Charlie Francis in that way. However, the evidence as it has emerged during the oral hearings suggests that this is a mis-transcription:

(i) Yan Paschali accepted in evidence that there is a different tone to "*in his mouth*" and "*where*" (suggesting that they are in fact said by two different people).[504]

(ii) In his evidence, Clayton Fraser was clear that: "*the 'where?' – not the 'in his mouth'; the 'where?' is Yan's voice*".[505]

Putting that together, it appears that Yan Paschali did not say "*in his mouth*" when Charlie Francis asked if the battery had been swallowed; and thus cannot rely on having done so in support of his contention to have believed at the time that the battery was in D1527's mouth.

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[500] See, e.g., Yan Paschali 24 February 2022 93/6

[501] CJS001107_0022, para 7.37

[502] TRN0000001_0011; it appears from the footage more clearly than the transcript that Yan Paschali was one of the officers this was said to.

[503] TRN0000002_007

[504] Yan Paschali 24 February 2022 123/2

[505] Clayton Fraser 28 February 2022 75/12-13

(d) Mr Collier in his follow-up report to Sussex Police rejected this explanation given by Yan Paschali in the following terms:[506]

> "At no time was there any dialogue or communication to indicate that the detainee had anything concealed in his mouth, or that DCO Paschali had concerns over the detainee choking. If he did have concerns then he would surely have stated this at the time and alerted other staff to the risk. The audio on the footage is clear and no mention was made of an item in the mouth or a risk of choking. If this was a medical emergency then the expectation is for staff to shout/alert others by saying 'medical emergency'. Training has been provided since January 2016 on how to manage a detainee experiencing medical problems. This includes how to adjust the supine technique into the restraint recovery position. At no time did DCO Paschali summon the healthcare staff, despite knowing that they had attended the incident. If he considered that the detainee was at risk I would have expected him to have reacted differently and certainly not to have continued with the pressure around the neck or the dialogue he was heard to use."

(e) Mr Collier also rejected Yan Paschali's purported justification in clear terms in his oral evidence to the Inquiry: "*He was saying that he was obviously looking at trying to retrieve something from the mouth of the detained person, and I don't see how the technique -- or what he was doing, I wouldn't call it a technique, the action he was carrying out, in any way would support that or would assist with that at that time.*"[507]

(f) As the PSU report concluded[508] – and consistent with Callum Tulley's evidence, it does appear that Yan Paschali dig his fingers into D1527's neck for the brief period during which he tells him he is going to put him to "*fucking sleep*". That is not consistent with an attempt to 'shock compliance' – which, being charitable to Yan Paschali, may have used shocking language, but would not have involved digging fingers into the neck. That is because, the Use of Force training manual to which Mr Collier has referred states in terms: "*Under no circumstances should staff put any body weight on the neck... of the person being restrained. Neither should there be any hold around the neck as otherwise blockage of the airway can occur... .*"[509]

372. For completeness, G4S also refers the Inquiry to Mr Collier's observations on this incident in his original report that:

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[506] CPS000004_0002-0003; see also INQ000158_0029, para 10

[507] Jonathan Collier 30 March 2022 28/23-29/4

[508] CJS001107_0024, para 7.47

[509] NOM000001_0078

(a) "*The force used by Yan Paschali does not replicate what is taught in training and is in fact a potentially dangerous and unlawful act. The medical advice provided to staff on all UOF training covers the medical risks associated with using force, and specifically applying any pressure to the head or neck area. I must question why colleagues and especially the supervising officer did not address this at the time and if necessary remove Yan from the incident.*"[510]

(b) "*The technique used by DCO Yan Paschali whilst controlling the head in the supine position does not meet any of the general principles, was disproportionate and potentially injurious*".[511]

Staff comments

373. Further, during and after the course of this incident, certain staff members made comments – some to D1527; some about him or the incident, that G4S contends were highly inappropriate. Indeed, a number were the subject of disciplinayr proceedings by the Company in relation to these.

374. These included:

(a) Jo Buss referring to D1527 has acting like an "*arse, basically*"[512]: she was summarily dismissed by G4S for this (amongst other aspects).[513]

(b) Charlie Francis made comments towards D1527 such as asking him if he was a "*man or a mouse*", and called him "*a baby*" and a "*tool*". His response in evidence was that "*I was just trying to shake him back to reality, get him back to reality, so he's not focusing on what had happened and trying to get him -- a response out of him*".[514] G4S does not condone that treatment of a detained person and Charlie Francis was rightly summarily dismissed as a result (including for other conduct in addition).[515]

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[510] INQ000111_0017, para 35; also INQ000111_0018, para 41

[511] INQ000111_0019, para 49

[512] TRN000006_0002

[513] CJS004054_0002

[514] Charlie Francis 3 March 2022 64/8-10

[515] CJS0072973

(c) In reference to D1527 having put a battery in his mouth, Nathan Ring crudely joked "*going all night, Duracell bunny, isn't he*".[516] Nathan Ring observed that comments like these were made outside D1527's room, and "*weren't comments directed at the time detainee*"; they were "*a bit facetious and a bit silly*".[517] Again, G4S had no tolerance for conduct of this kind and Nathan Ring was summarily dismissed for this (amongst other conduct).[518]

(d) Subsequently, on 4 May 2017, Clayton Fraser referred to this incident when asked how to deal with a detained person on the netting, answering: "*What Yan did*".[519]

Absence of use of force reports

375. A notable failing in relation to the incident was that no use of force paperwork was filed by Yan Paschali, Clayton Fraser, Charlie Francis or Callum Tulley in relation to the incident (not including the cutting of the ligature by DCM Loughton, in respect of which a report was filed).

376. Mr Collier rightly observed that:[520]

> "There is no reasonable reason for not completing UOF reports. All staff involved would be aware of their responsibilities and complete a statement even if a colleague tells them otherwise. It is a personal account and does not require authorisation from a senior member of staff".[521]

377. That is, of course, right; and it includes, in this case, Callum Tulley. Documentation and reporting are a key part of the oversight and governance mechanism and, had this paperwork been completed, the incident is more likely to have come to the attention of senior management or, for example, the IMB – prior to the airing of Panorama.

378. The footage records Yan Paschali telling Callum Tulley: "*that wasn't a C&R, really. Don't worry about it*";[522] and subsequently "*as it stands, no use of force as it stands*", to which

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[516] TRN0000001_0006

[517] Nathan Ring 25 February 2022 77/11-17

[518] HOM001503

[519] TRN0000005_0001

[520] INQ000111_0018, para 42

[521] See also CJS001107_0024, para 7.53

[522] TRN0000006_0012

Callum Tulley responds "*no use of force report? Okay*".[523] Jo Buss subsequently asked Callum Tulley: "*are they putting that down as a restraint?*" to which he responded: "*I think as it stands, according to what Yan just told me, they're going to leave it*".[524] He added, "*it's going to be down to Dixie*".[525] In his oral evidence, Callum Tulley described this as "*a deployment of an undercover tactic in which I was putting the responsibility onto a manager rather than myself being responsible, because, I mean, I was -- I was kind of being asked about wrongdoing and I didn't want to encourage any form of wrongdoing, so I -- I put -- I deflected the question.*"[526]

379. What is of concern is Callum Tulley and Jo Buss' reference to 'they'. The obligation, as Mr Collier points out is not on a senior officer to complete a use of force report. Indeed, Callum Tulley was not in a position to 'deflect' responsibility onto a manager as to whether a Use of Force report should be completed. That was a question to which he knew the answer and was under an obligation to complete. He explained that he "*didn't want to encourage any form of wrongdoing*", but failing to complete a Use of Force form when, in reality, he knew that he had to – was, itself, a form of wrongdoing committed by Callum Tulley. It is submitted that there is nothing about his undercover role which would have been inconsistent with him filing a UoF report in relation to the incident on 25 April 2017. Indeed, it is to be recalled that Callum Tulley was the first intervening officer when the incident began with D1527's attempt at self-strangulation.

380. It is right to note that it is Yan Paschali's evidence that he did in fact complete a UoF (or incident) report, which he left in the pigeon hole on the E wing office desk.[527] He went on to suggest that it had been found and destroyed by Callum Tulley.[528] G4S has no hesitation in inviting the Chair to disregard that suggestion. It further submits that in light of Yan Paschali's generally implausible account, that the Chair should find that – on the balance of probabilities – Yan Paschali never did complete a UoF report. Indeed, it would be surprising if he had done so, alongside suggesting to Callum Tulley that it was unnecessary "*as it stands*". Additionally, G4S endorses the PSU's suspicions regarding the supposed

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[523] TRN0000006_0014

[524] TRN0000006_0015

[525] TRN0000006_0015

[526] Callum Tulley 1 December 2021 129/4-8

[527] Yan Paschali 24 February 2022 149/7-19

[528] Yan Paschali 24 February 2022 151/14

coincidence that neither Clayton Fraser nor Charlie Francis had completed UoF reports either, concluding "*it seemed more likely than not that there was some consensus that the event was not disclosed*".[529] This aspect also featured in the summary dismissal of both Clayton Fraser and Charlie Francis. G4S submits that it is open to the Chair to find, at least on the basis of a suspicion, that there was collusion between Yan Paschali, Clayton Fraser and/or Charlie Francis not to file use of reports, in circumstances in which all three individuals must have realised it was necessary to do so. Neither Clayton Fraser nor Charlie Francis could give a good reason when questioned why they did not do so: Charlie Francis simply said he did not know;[530] Clayton Fraser said that he was not in the right "*frame of mind*"[531] and was "*exhausted*".[532] Neither of these answers is compelling; and bring the PSU's concerns about a 'consensus' into relief.

4 May (Row 13)

381. This incident concerns D1527 jumping onto the D wing netting on 4 May 2017 with a piece of broken plate that he held against his neck, following which he agreed to come off the netting, on the condition that there were no officers around. Once off the netting, Steve Dix informed D1527 that he would need to go to the CSU / E wing on rule 40; D1527 refused, put his hand in his pockets, as if he was trying to retrieve something, and force was used to escort him to E wing.

382. This incident was assessed by both Mr Collier and the PSU. G4S broadly accepts both of their conclusions. As a starting point, however, it is right to recall that D1527's own evidence is that he jumped onto the netting, held a piece of broken plate against his neck and threatened to jump.[533]

383. Steve Dix agreed to D1527 coming off the netting in the absence of staff, but shortly thereafter went to inform D1527 that he was to go to the CSU / E Wing on rule 40. He explains that he told D1527 that staff members "*could not leave him alone because of the way he was behaving*" and as a result he would need to go to the CSU. D1527 refused; and

[529] CJS001107_0026, para 7.60

[530] Charlie Francis 3 March 2022 72/14-23

[531] Clayton Fraser 28 February 2022 87/23

[532] INQ000137_0004, para 22

[533] DL0000144_0026, para 71

Steve Dix explained that, as a result, force may be used. Force was then use when D1527 reached into his pocket, and Steve Dix was concerned for D1527's and his own safety, given D1527's history of self-harm – because he was concerned that D1527 was reaching for a weapon.[534] D1527's own evidence is that he had his phone in his hand and threatened to swallow it.[535] Having initiated force, Steve Dix then withdrew and control was applied by DCOs Bromley, Shaukat and Yates; Steve Dix then applied handcuffs.[536]

384. Mr Collier's observation in relation to this is that: "*This all appears to be consistent with training and force being applied lawfully and only when necessary. The application of handcuffs helped with the de-escalation process and D1527 was then stood upright and escorted to the CSU*".[537] He also complimented (seemingly) Steve Dix for substituting himself for DCO Yates when D1527 starts to get angry towards the latter:[538]

> "In my view this an excellent example of removing a trigger from an already frustrated and angry young man. If D1527 did have an issue with DCO Yates the decision to remove him would be a sign of co-operation and that all attempts at de-escalation are being explored."

385. His overall conclusions, which G4S invites the Inquiry to adopt are:[539]

> "*Good practice*
>
> 285. The initial restraint does not raise any major concerns and appears to meet the lawful application of necessary and proportionate, other than no BWVC being activated. Good de-escalation once handcuffs are applied and allowing D1527 to stand upright.
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> 286. Really good decision to remove a trigger from the restraint and replace with another member of staff.
>
> …
>
> *Summary*
>
> 290. *Last resort* - all reasonable efforts through persuasion and negotiation failed and force was the last option available to facilitate the move
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> 291. *Necessary, reasonable, proportionate* - The level of force used, and the necessity are all justified and there is no evidence that anything other than reasonable force was used. Handcuffs were applied and when D1527 emerges from the room he is stood upright, indicating that after the initial

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[534] CJS005530_0008

[535] DL0000144_0027, para 75

[536] INQ000111_0069, para 271

[537] INQ000111_0070, para 272

[538] INQ000111_0071, para 277

[539] INQ000111_0072-0073

> force was used the restraints were removed once handcuffs had been applied.
>
> 292. *No more than was necessary* - Only handcuffs."

386. This is broadly consistent with the PSU's investigation of the incident, which found the allegation in relation to this incident to be unsubstantiated. Its analysis included:

(a) "*The BWC footage captured staff behaving professionally towards D1527 and explaining what was happening*".[540]

(b) "*D1527's complaint related to the use of force in his room when he alleged six guards rushed in and assaulted him. CCTV showed DCM Dix spoke to D1527 for nine minutes trying to persuade him to move to E Wing, before the of force began*".[541]

(c) Further:[542]

> "The officers' accounts of the use of force and the subsequent journey to E Wing were supported by the camera footage. There initial force was used as DCM Dix was concerned D1527 vas going to take something out of his pocket and DCM Yates believed D1527 made a threat. Given that D1527 I had self-harmed on a number of occasions both DCMs were aware of his high risk and therefore it was considered that the action to use force appeared necessary and justified in the circumstances. It was noted that when D1527 left his room, DCO Shaukat did not control his head and when D1527 became disruptive as they left the wing, DCO Shaukat took control again, but released his hold soon after. This was .proportionate to the level of resistance D1527 showed… There was no evidence that excessive force was used, or that staff were unprofessional during the use of force."

387. These conclusions are sound, and the Chair is invited to adopt them.

388. There are two particular aspects of this incident that arose in evidence and should be addressed.

389. First, in D1527's closing statement, his counsel suggested that there was "*outlawry, on 4 May, under the guise of rule 40*" which was "*planned and intentional*": "*The footage confirms the intention was to punish or impose some perverted sense of discipline on him for his self-harming activities.*"[543]

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[540] CJS001107_0028, para 7.84

[541] CJS001107_0029, para 7.88

[542] CJS001107_0030, para 7.88

[543] Closing Statements 5 April 2022 63/9-14

390. That is absolutely not the case. It is correct that Steve Dix said in oral evidence: "*At the time, obviously, when someone is on the netting, then obviously the procedure was for them to go to rule 40*".[544] That is not to say that it was an 'automatic punishment' for someone who went on the netting to be put on Rule 40. Rather, considering that the netting was designed to protect those with suicidal intention from harm, it would often be the case that someone who jumped on the netting had, at the time, suicidal ideation and possibly intent. In those circumstances, particularly if the jump on the netting was a form of suicide attempt, it would be appropriate for that detained person to be placed on a constant watch, given their state of vulnerability. Indeed, consideration of the Rule 40 documentation in this case[545] demonstrates that point, as D1527 was put on constant watch for a couple hours. It is also reinforced by what DCM Dix wrote in his UoF report, explaining to D1527, in relation to why he was being put on Rule 40 that: "*I tried to explain the reason that [staff] could not leave him alone was because of the way he was behaving*":[546] i.e. where he has threatened or attempted self-harm, he will be need to be put on constant observations by staff in order to protect him from harm.

Secondly, in his oral evidence, Mr Collier was asked about the application of a PIT on D1527.[547] The source of this is DCO Yates' UoF report, in which he states: "*Just before leaving the wing Mr D1527 began struggling and pushed his way to the wall. After a struggle I applied the thumb flexion/lock back onto Mr D1527*".[548] In his first supplementary report he wrote in relation to this issue: "*Based on the description of DCO Yates and the evidence from the footage where staff struggle once they reach the door the use of a PIT would be justified.*"[549] In his oral evidence, he explained that "*there is very little to state or to justify why that decision was made [to apply the PIT]*"; and when asked if it was justified in the circumstances, he responded: "*there is no evidence to suggest it was, no. So there was nothing to say that there was such risk or such potential risk…* " (emphases added).[550] It is important to note that Mr Collier is not saying here that the use of a PIT was not justified; rather that there is no evidence or explanation given to justify its use. As noted above, Mr

[544] Steve Dix 9 March 2022 56/1-3

[545] HOM000251

[546] CJS005530_0008

[547] Jonathan Collier 30 March 2022 133/3-137/12

[548] CJS005530_0018

[549] INQ000158_0084

[550] Jonathan Collier 30 March 2022 135/20-136/8

Collier explained in his first supplementary report that in the case of a struggle a PIT would (or at least could) be justified. It is right that DCO Yates' description in his UoF report is relatively thin on reasoning, so as to give a clear and comprehensive evidential basis to justify the application of the PIT. Accordingly, on a proper reading of Mr Collier's evidence, it is not that the use of a PIT was not justified; but rather that there is not a clearly set out justification for it. It is not that a justification does not exist; but, if one does – and it could (see the first supplementary report) – it is not satisfactorily explained in the documentation. G4S accepts that criticism. Indeed, it is to be recalled that on this particular point the PSU observed that: "*DCM Yates recorded his use of pain control and CCTV supported his account of the level of disruption at that time*".[551]

Overall observations

391. As explained above, G4S agrees that the incident involving D1527 and Yan Paschali on 25 April 2017 was the most serious shown on Panorama. There is no excuse for Yan Paschali's conduct and G4S repudiates his purported justifications for his actions: there were none.

392. It does not automatically follow, however, that such treatment constituted a breach of Article 3 ECHR: G4S submits that such a threshold was not crossed; and certainly not to meet the definition of torture (see the submissions above on the exceptionally high threshold that would need to be crossed). As CTI helpfully pointed out in their note on Article 3, "*an episode of relatively short duration would not likely reach the necessary level of suffering and humiliation to qualify as torture*".[552] This was precisely that: as Callum Tulley explained in evidence, Yan Paschali only put pressure on D1527's neck for around six seconds or so. On any view, that is a period of incredibly short duration – and a far cry from the types of conduct, sessions of beating and other protracted mistreatment that is found in the case law on torture. Indeed, it is D1527's own evidence that he does not remember what Yan Paschali said to him while his hands were on his neck.[553] The type of conduct that constitutes torture is extreme, and the Inquiry is invited to recall that in the *Ireland* case wall-standing, hooding, subjection to noise and deprivation of sleep, food and drink were not serious enough to meet that threshold – even though their duration was substantially longer

[551] CJS001107_0030, para 7.88

[552] CTI's Note, para 21

[553] DL0000144_0019, para 49(43)

than Yan Paschali's 'choke hold'. Moreover, torture is typically done for a purpose (e.g. the extraction of information). Whatever may be said about Yan Paschali's deplorable conduct, there has not been evidence before the Inquiry of it being done for a particular purpose that would form part of a torture finding.

393. Much is said about the nature of E wing exacerbating D1527's mental state, but officers were in a bind: D1527 was a detained person with a known history of self-harm, often attempting further harm to himself. In those circumstances, D1527 needed to be on constant observations precisely to protect him from further self-harm incidents. It was the particular rooms on E wing / the CSU which were set up for constant observations, and – while he was in Brook House – when his condition was more acute and he required constant observation, that was the most appropriate place for him to stay. For him to be anywhere else would have been a dereliction of G4S' obligations to monitor and care for a detained person at serious risk of self-harm. Time spent on E wing was thus not a 'punishment' for self-harm. Although it may have followed a self-harm event, it was not for punitive reasons or to disincentivise future conduct, but rather to enable staff to intercede in advance to prevent any future harm.

Row 12: Use of force against D191 on 27 April 2017

394. This was an incident in which force was used against D191 following a combination of his own strange behaviour with D191 striking D356 with a television remote control. This account is corroborated by D356, who told the PSU that D191 struck him with the remote control with such force that the remote control broke.[554] Force was required to restrain D191 in the circumstances to prevent any further harm, and he was taken to the CSU. In the circumstances, this was an unplanned use of force. This is also an incident which has been the subject of Mr Collier's scrutiny and, indeed, his criticism.[555] As such, G4S' submissions and observations in relation to it are made (in the first instance) by reference to Mr Collier's opinions.

395. DCM Steve Webb's primary account of the incident is contained in the Use of Force report pack.[556] There is no real challenge to DCM Webb's account by Mr Collier, nor in DCM

[554] CJS002741_0018, para 6.12.5; CJS002741_0021, para 7.1.23

[555] INQ000111_0045-0049

[556] CJS005549_0009

Webb's oral evidence to the Inquiry on the incident.[557] Rather, the key issues in relation to the incident concern the appropriateness and application of the techniques deployed in the particular circumstances.

396. Again, it should be stated at the outset that G4S recognises and accepts Mr Collier's expertise. It broadly (but not necessarily in *every* case) accepts his opinions – but notes that these are more open to question where: (a) there are reasons to question the factual basis on which Mr Collier had formed his opinion (given that his expertise concerns giving *opinions*, rather than deciding *facts*); and/or (b) further evidence has arisen since Mr Collier produced the relevant report[s], upon which Mr Collier has not commented (e.g. where further explanations are given by those concerned, which impact the underlying factual picture). In relation to this incident, it is important to note that the relevant video footage comes from CCTV.[558] That, itself, is part of Mr Collier's criticisms, and is addressed (and accepted) below. However, that footage consists of small images and is somewhat grainy. Certainly, one cannot see close-up details of holds and restraints in the CCTV footage available. That is no criticism of Mr Collier, but is a relevant consideration when it comes to the issue of wrist flexions/locked, considered below.

397. First, it is important to recall that Mr Collier's assessment of this incident is that the use of force, itself, was appropriate (subject to his subsequent criticisms of how it was carried out). As he noted, "*the initial UOF appeared justified by being reasonable and proportionate…*";[559] and "*staff reacted to an incident and used force to prevent injury to a third party. Using force was the only option at the initial stage*".[560] Relatedly, the incident was the subject of detailed consideration by the PSU[561], see its conclusions at paragraphs 7.1.2-7.1.52. These are also summarised by Mr Collier at paragraph 176 of his report (including the conclusion that "*Unsubstantiated claim of excessive force and inappropriate segregation. The officers acted in accordance with training, policy and procedures*"), and he adds at paragraph 177: "*I agree with the conclusions of the investigating officer, which are further justified when taking into consideration the third-party evidence*".

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[557] Steve Webb 8 March 2022 163/3-175-13

[558] Disk 3 UOF 109 17 27Apr2017 1809-1821: D1 – B3 – A3 – D2 – (6:11-9:09).

[559] INQ000111_0047, para 178

[560] INQ000111_0048, para 186

[561] CJS002741

398. There are then four particular points in relation to which Mr Collier makes criticism of the execution of the use of force by staff. Taking these in turn:

(a) Camera: Mr Collier's criticism is that when staff attended the room, he would have expected DCM Webb to activate his body-warn camera.[562] A similar criticism is made (in less clear terms) by the PSU.[563] G4S accepts and agrees with this particular point of constructive criticism (and DCM Webb, himself, accepted that he failed to turn the camera on, observing that he had yet to 'get into the habit' of doing so).[564] Of course, activation of a camera is a question of proper operational practice; it does not change the nature of the underlying incident or form part of the force used/not used on D191.

(b) Healthcare: Mr Collier further observes that: "*Healthcare are not in attendance and this would cause a risk if during the restraint a medical emergency, or injuries, occurred*".[565] There is a point of factual clarification to be made here. Mr Collier is correct that healthcare were not present for the use of force, itself. However, it is to be recalled that this was an unplanned use of force incident (in respect of which it is not always possible to ensure that healthcare are present, given the spontaneous nature of the incident). Indeed, it should be recalled that the particular trigger for force to be applied was D191 hitting another detained person with a remote control – which is why DCM Webb explained that healthcare was not called until after D191 had been restrained.[566] In his oral evidence, DCM Webb explained that in an unplanned incident such as this, healthcare would not be called while the incident was taking place, but promptly once it was over: "Healthcare wouldn't have been called until I got to the CSU, probably I went back to E wing, went straight into E wing and got the nurse down. But you wouldn't call healthcare – healthcare would come down afterwards."[567] That is also consistent with the use of force paperwork, which shows that although healthcare were not present during the use of force, itself, Donna Batchelor of the

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[562] INQ000111_0046, para 172

[563] CJS002741_0022, para 7.1.27.

[564] Steve Webb 8 March 2022 161/8-21; 169/8-10

[565] INQ000111_0046, para 172

[566] Steve Webb 8 March 2022 171/10-18

[567] Steve Webb 8 March 2022 169/16-22; also 171/10-18

healthcare team attended D191 only 15 minutes after the incident had taken place to examine him.[568]

(c) Handcuffs/wrist flexion: Mr Collier questions: "why handcuffs were not used and that the continued use of wrist flexion was maintained, and importantly maintained when moving down stairs without adopting the correct procedure";[569] and adds, in the context of his proportionality analysis that: "*I do not believe it was reasonable to maintain wrist flexion throughout when the use of handcuffs would have been a more suitable option, and that would present less risk of injury*".[570] Importantly, Mr Collier concludes as a result of this view that: "*[maintaining wrist flexion] was not proportionate to the risk, if as suspected the behaviour demonstrated was due to taking an illicit substance*".[571] Mr Collier's view, therefore, is that the use of wrist flexion rather than handcuffs reflected a greater amount of force than was strictly necessary (although noted and agreed with the PSU's conclusion that there was no note of a complaint about any injury caused by this).[572] It is important at this juncture to recall the shortcomings in the footage viewed by Mr Collier which does not show a close-up image of the restraint. For that reason, it is understandable that Mr Collier did not see – as DCM Webb explained in oral evidence in relation to the use of wrist flexion:[573]

> "Q. …Was wrist flexion a form of pain compliance?
>
> A. You could use pain compliance but there was no pain compliance there. The locks were loose. He was quite easily able to move his hands. He was under control. Handcuffs, I wouldn't want him in handcuffs because we always handcuffed to the front and, if he's on a substance and he goes into some sort of fit, I would want to be able to do first aid on him and, handcuffs to the front, you wouldn't be able to do -- so you put handcuffs on, as soon as the medical incident happens, you've got to take handcuffs off, and if you've seen the key and the hole of the handcuffs, it's not easy, in a medical emergency, to get the cuffs off. I wouldn't use cuffs because he was on something. If he went into a medical emergency, I'd have to take the cuffs off, which would waste time in me giving first aid.
>
> Q. Do you think that you were using wrist flexion in this instance as a form of pain compliance?

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[568] CJS005549_0020 (on the timings, compare that page with 0001 of the same document).

[569] INQ000111_0046, para 172

[570] INQ000111_0048 para 187

[571] INQ000111_0048 para 187; see also para 188

[572] INQ000111_0047 para 176

[573] Steve Webb 8 March 2022 173/8-174/2

A. No, there was no pain being used"

As such, while Mr Collier considered – from what he had seen in the footage – that handcuffs would have been a more suitable restraint, when he submitted his report (and his first supplementary report) he did not have the benefit of DCM Webb's account given on 8 March 2022 to the Inquiry. That account is not only credible, but contains two important points: first, that the wrist flexion used in this incident involved loose locks, enabling D191 to move his hands freely, such that he was under control but the force used was limited. This is also consistent with the absence of any injury to D191's wrists noted by Donna Batchelor. Secondly, there was a particular practical and medical reason why DCM Webb decided not to use handcuffs: namely that given that D191 appeared to be under the influence of narcotics, if he fitted while under restraint, it would inhibit the giving of first aid if handcuffs needed to be removed during the medical emergency. That is ostensibly a credible reason why a loose wrist flexion would be preferable to the use of handcuffs in this particular instance; one that Mr Collier has not since addressed (let alone rejected).

(a) Staff present: Mr Collier also criticised the handling of the incident in that there was a "*lack of support staff when moving on the stairs and lack of senior managers*" (although noting that this criticism did not alter his overall view on the use of force).[574] Similarly, "*the technique used on the stairs was incorrect carried a considerable risk for all involved by either losing their footing or falling during the struggle. This would have been avoided by using additional staff, as directed in training, and using them as a brace for moving up/down stairs to secure the movement and to prevent falling.*"[575] Again, the unplanned nature of the use of force is relevant here. DCM Webb's oral evidence is also compelling, and where it digresses from Mr Collier's views, it has since gone unanswered. First, DCM Webb accepts that he should have alerted more staff "*if there was more staff to actually alert*" (emphasis added).[576] DCM Webb's evidence was therefore that it would only have been appropriate to call for more staff, if there were additional officers nearby and, from context, it appears that there were not, given his evidence that: "*bringing more officers onto the wing would just incite*

[574] INQ000111_0047 para 179

[575] INQ000111_0048 para 182

[576] Steve Webb 8 March 2022 170/21-24

the situation".[577] He explained that if he called a first response, "*they'd all come charging onto the wing and obviously everyone would be alerted*".[578] Further, in respect of Mr Collier's specific criticism regarding the technique used on the stairs, he explained:

> "There is a technique to move up and down the stairs, yes, there is. But I don't believe it was necessary there. I was the brace. I'm more than enough -- I'm more than three officers' weight, so I'm more than enough of a brace. And I needed to get him to CSU quickly because I wanted to get healthcare to see him because I believed he was on some sort of substance. So that would be more officers, it would take time, he needed to get to CSU. So I was more than the brace."[579]

Putting these points together, DCM Webb accepts Mr Collier's view that there is an accepted technique to navigate the stairs, but noted that this would have required a greater number of officers. Calling for further support: (a) would have taken time, when he needed to move D191 to the CSU swiftly so he could be seen by healthcare; and (b) could have escalated the situation, as it would have entailed the first response team "*charging onto the wing*". Given both those risks, as well as the contextual information of DCM Webb's own substantial size, he took the operational view, in the moment, that it would be safer overall (balancing the risks of moving D191 as a 'three', versus delay or escalation in getting him to the CSU) to move D191 without calling for further staff. The relative weight of those risks may well be a question of delicate operational balance, on which different DCMs could validly take different views. However, DCM Webb's explanation is a credible one; and it is suggested that the Inquiry should show some deference and understanding towards his need to take an operational decision 'in the moment', particularly where Mr Collier has not taken the opportunity to discuss (or reject) this ostensibly-credible explanation given in evidence.

399. Even taking Mr Collier's criticisms at their very highest – before considering, for the reasons given above, why some of them may not apply (at least not to their fullest extent) – particularly in relation to the use of the wrist flexion and the stairs technique, this is not a 'mis'-use of force that comes anywhere near to engaging D191's Article 3 rights. The Inquiry is invited to accept the conclusions of the PSU in relation to this incident, supported

[577] Steve Webb 8 March 2022 171/1-3

[578] Steve Webb 8 March 2022 171/6-8

[579] Steve Webb 8 March 2022 172/5-13

as they are by Mr Collier; and to consider Mr Collier's own criticisms as ones of technique execution, rather than substantial criticisms as to whether (e.g.) force should have been applied at all. There are plainly judgment calls at play here – for example in relation to the use of wrist flexion where there was a perceived risk of fitting; the decisions taken by DCM Webb were evidently with the detained person's safety at the forefront, and certainly not to degrade.

Row 16: Use of force against D687 on 13 May 2017

400. This use of force incident was one of those shown on Panorama. It was unplanned;[580] and took place in the context of the intended transfer of D687 from Brook House to the Verne. Before that transfer could be effected, staff observed D687 in the toilet of a holding room with a ligature around his next, which was tied to a fixture. Staff engaged with D687, who resisted attempts to move him from Brook House, threatening to harm himself.

401. That is the general backdrop to an important incident which the Inquiry is considering. It has been the subject of scrutiny (including criticism) from Mr Collier;[581] and the PSU.[582] The Inquiry has the benefit of footage of the incident from Callum Tulley;[583] as well as witness evidence – in particular that from D687, himself, Callum Tulley, Dan Haughton, Chris Donnelly and Shane Farrell. At that outset it is important to point out that of those five key witnesses in relation to this incident, the latter four all gave live evidence, giving the Inquiry the opportunity to test their account; explore their evidence, and to probe it. D687 has provided a witness statement to the Inquiry,[584] but did not give live evidence. In the circumstances, save where it is supported by incontrovertible documentary evidence, or corroborated by other witness evidence, G4S invites the Inquiry to place limited reliance on D687's account, given the inability of the Inquiry (and other Core Participants via the Rule 10 process) to challenge his written evidence – particularly where D687's account challenges or is contradicted by the evidence of other witnesses. G4S invites the Inquiry to take that

[580] CJS005652_0001

[581] See his initial report at INQ000111_0055, para 214ff; as well as his first supplementary report, including at INQ000158_0018, paras 3.6-3.8 and INQ000158_0046 at para 18.7-19.2; and INQ000158_0052 at para 21.4ff.

[582] HOM002725

[583] KENCOV1016 - V2017051300011; KENCOV1016 - V2017051300012

[584] DPG000021

approach: (a) as a matter of fairness to those witnesses who were subject to examination by CTI, which was rigorous and at times better characterised as 'cross-examination'; and (b) in particular in circumstances where there are stark contradictions between the account given by D687 in his witness statement to the Inquiry[585] and the witness statements filed by D687 in January 2018 as part of judicial review proceedings.[586] By way of simple example, in his statement of 8 January 2018, at paragraph 26 D687 refers to "*suddenly the w/c door was broken down by detention officers and several stormed into the room. I think there were about 6 officers, including a senior officer called Nathan...* ".[587] By contrast, in his statement to the Inquiry, there is no mentioned of or reference to officers 'storming' into the toilet (or equivalent language), nor are any of the officers identified by D687 as involved called Nathan.[588] That is but one example, but the simple point is that these inconsistencies at the very least cast considerable doubt on D687's credibility and the Inquiry (including other Core Participants) have not had an opportunity fairly to test D687's evidence through live evidence and the Rule 10 process. The point is made stronger in light of the errors and inconsistencies found in D687's account by both:

(a) The PSU, which concluded that (amongst other things):

(i) D687 had "*attempted to embellish his account that the use of force was excessive*", as the Panorama footage showed that the t-shirt had not been cut into strips;[589]

(ii) D687 was "*internally inconsistent across his accounts*", e.g. changing his account on the fundamentally important question of whether he had in fact tried to hang himself before officers arrived on the scene;[590]

(iii) D687 changed his account regarding whether the toilet door had been locked and whether officers had kicked it open: his account "*of how officers entered the room and instigated force was inconsistent*";[591]

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[585] DPG000021. Note that it is also unclear to G4S whether this statement has been *signed* by D687.

[586] HOM002446 and HOM002450

[587] HOM002446_0004

[588] On the latter point see DPG000021_0072, para 206.

[589] HOM002725_0040, para 7.5.7

[590] HOM002725_0040, para 7.5.8

[591] HOM002725_0040, para 7.5.9

(iv) D687 has made a "*completely false assertion*" regarding the presence of DCMs Nathan Ring and Steve Webb and the evidence suggested that D687 had added these two officers to the excessive use of force claim in light of their other actions shown on Panorama, which "*seriously affected D687's credibility*";[592]

(v) D687's account "*continued to be inconsistent in respect of how the t-shirt was removed… The kick in the ribs changed to a punch. The officer sat on his back had been Steve, who was not present*";[593] and

(vi) D687's account of what happened was not found to be credible "*in any aspect other than force was used on him to remove him from the toilet area and prevent his hanging himself*".[594]

(b) Mr Collier also observed that paragraph 26 of D687's (8 January 2018) statement "*does not reflect what is seen on the footage available. Staff did not storm the room and from the footage the general demeanour was calm, with staff stood relaxed and the door open*";[595]

402. The clearest evidence available to the Inquiry is that contained within Callum Tulley's footage, as well as the CCTV available, both of which were made available to Mr Collier. As a starting point, Mr Collier observed that "*staff were trying to negotiate from inside the cubicle and adopted a relaxed, non-threatening posture. They were ideally placed to respond if D687 carried out his threat [to self-harm]*".[596] Further, "*The actual engagement with 0687 meets the expectation of staff and they display a calm demeanour through this period whilst attempting to resolve the situation*".[597] This was an area of good practice. Further, Mr Collier has opined that: "*Necessary, reasonable, proportionate: Once the decision to end the incident was made the force used was proportionate in the main, with the exception of a leg restraint being used for no apparent reason*";[598] and "*No more than*

[592] HOM002725_0040, para 7.5.10

[593] HOM002725_0041, para 7.5.11

[594] HOM002725_0041, para 7.5.13

[595] INQ000158_0047, para 18.9

[596] INQ000111_0059, para 230

[597] INQ000111_0056, para 219

[598] INQ000111_0061, para 239

was necessary - The force used did not exceed that which was necessary, except the leg restraint. The application of handcuffs resulted in the restraints being removed."[599]

403. First, G4S accepts Mr Collier's criticisms that:

> "The use of BWVCs do not appear to have been in operation at the time. This should be addressed in order to remain consistent with other custodial settings. The lack of a handheld camera for the incident is also not acceptable. G4S had protocols in place and they were not carried out by two DCOs."[600]

404. Indeed, Mr Collier recognises that the appropriate protocols had been put in place by G4S, but that these had not been followed on this occasion by the DCOs.

405. There are two further substantive criticisms made by Mr Collier:

(a) The first, and arguably the most important is that in relation to the conduct of the duty director, Daniel Haughton.

(i) Mr Collier describes Daniel Haughton's conduct as "*seeing that D687 has an unlit cigarette he offers to light the cigarette and uses this as a ploy to move closer and initiate a restraint*".[601] It is right to note that in his oral evidence, Mr Collier clarified that there were two aspects to the incident: first, Daniel Haughton moving in to remove the ligature; then the use of force by staff which "*followed almost immediately*". The former was not, itself, a use of force.[602] However, Mr Collier was "*concerned*" by Daniel Haughton's actions on the basis that:[603]

> "Using subterfuge as a means to get closer can remove all trust that a detainee has in staff and will make future incidents more difficult to resolve. Additionally as the senior person he should not have become actively involved and should have taken a supervisory role, where he could monitor the staff and detainee. Due to the lack of immediate risk he could have ensured the incident was recorded on an official device and that healthcare were in attendance. This incident should have been managed as a planned incident."

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[599] INQ000111_0061, para 240

[600] INQ000111_0060, para 235

[601] INQ000111_0055, para 216

[602] Jonathan Collier 30 March 2022 93/13-18

[603] INQ000111_0057, para 221

(ii) G4S accepts this criticism of Daniel Haughton's approach. The key point is that in Daniel Haughton's own evidence, he accepted that he: "*could see that the way the knot was tied and the position on the toilet meant that even if D687 had dropped, it would not have put tension on his neck.*"[604] This is consistent with the absence of any significant immediate risk to D687, although it is right to note that in his oral evidence Daniel Haughton added that: "*The risk was still relatively low. It might not have strangled him. I couldn't be 100 per cent sure. Hence why when I had the opportunity to secure it and remove that risk, I did. Who is to know what would have happened if he'd dropped. He could have banged his head on the toilet bowl and suffered a severe head injury.*"[605]

(iii) G4S therefore accepts Mr Collier's overall view that Daniel Haughton should not have intervened in the manner in which he did, particularly as doing so was not anticipated or necessarily clearly understood by other staff present (as Daniel Haughton accepted in oral evidence).[606] Indeed, as Mr Collier observes, Daniel Haughton should have maintained a supervisory role, rather than participating in the incident directly. Mr Collier does not consider that force here was used as a last resort, given that "*staff were engaging with D687 and it appears that once DD Haughton arrives he is intent on resolving the situation by any means possible*".[607] Respectfully, Mr Collier can only speculate as to Daniel Haughton's intent at the time. Daniel Haughton's evidence is that:[608]

> "My intention throughout all of that was to remove that ligature, because by removing the ligature from the rail, it neutralised the incident and the situation. So, at the time, I was acting in what I thought was the best interest of everyone involved to try and bring it to a very quick and swift end"

(iv) That was not a desire to rush in and end the situation, come what may, but to provide a swift and safe resolution.[609]

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[604] SER000453_0036, para 161

[605] Daniel Haughton 16 March 2022 111/18-112/2

[606] Daniel Haughton 16 March 2022 115/3-12; 110/15-23

[607] INQ000111_0060, para 238

[608] Daniel Haughton 16 March 2022 109/4-9

[609] See Daniel Haughton 16 March 2022 111/1-3

(v) G4S accepts Mr Collier's view that instead of taking this approach, in light of the low risk to D687 at the time, staff could instead have returned to deal with D687's transfer as a planned (rather than unplanned) use of force. The two key advantages of taking that approach would have been: (a) healthcare would have been present on the scene; and (b) it would have ensured that all staff were 'on the same page', rather than officers reacting 'on instinct'[610] to Daniel Haughton's move to remove the ligature. Indeed, the fact that the rest of the team did not know what was going to happen was something on which Daniel Haughton had reflected and he accepted he could have dealt with the incident differently.[611]

(vi) It should, however, be recognised that Daniel Haughton was taking a decision 'live' on the basis of a dynamic risk assessment. Although he could have walked away and dealt with the situation as a planned use of force, he points out that doing so would have carried its own risks, namely that it would have prolonged the incident by 30-40 minutes.[612] In relation to Mr Collier's view that "*negotiation and persuasion should have continued*",[613] Daniel Haughton was entitled to take into account that staff had been "*engaging with [D687] for quite a period of time*';[614] Mr Collier points out that this was 11 minutes.[615] Daniel Haughton was entitled to take the view that because the trigger for the incident was the transfer to another centre, it was very unlikely that the situation would have de-escalated to the point where D687 would have voluntarily walked to the transfer without the need for force.[616] This view is supported by the conclusion of the PSU that "*D687 wished to frustrate any moves, even moves between centres*".[617] This is important because, although the incident could have been managed as a *planned* (rather than unplanned) use of force, it is almost certain that force would need to have been used. The key differences would have been

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[610] Daniel Haughton 16 March 2022 111/4-6

[611] Daniel Haughton 16 March 2022 110/17-25

[612] Daniel Haughton 16 March 2022 109/18-24

[613] INQ000111_0061, para 238

[614] Daniel Haughton 16 March 2022 112/24-25

[615] INQ000111_0056, para 220

[616] Daniel Haughton 16 March 2022 113/1-6

[617] HOM002725_0039, para 7.5.5

the presence of healthcare and potentially better coordination between the staff team.

(b) The second relates to Callum Tulley placing D687 in a leg restraint – which should only be done "*when necessary and when the control is being compromised by excessive movement or resistance*".[618] Mr Collier could not see any evidence to suggest that a leg restraint was necessary on this occasion and concluded that it was disproportionate, although did note that Callum Tulley "*struggled to gain control of an arm and was replaced by a colleague. This may have resulted in trying to make amends for his inability in controlling an arm.*"[619] Callum Tulley's evidence provides an answer to Mr Collier's concerns; recognising Mr Collier's view that restraint of the leg is justified where necessary (e.g. where it is being used to resist restraint), Callum Tulley explained:

> "Shane Farrell then took control of the right arm, because I was failing to get control of it myself, and Mr Collier actually does say in his report that when you're struggling to gain control of the body, particularly if a detainee is using their legs to resist restraint, then, in those circumstances, the restraint of the leg is justified, and given my efforts to restrain the right arm, which had failed, and his intentions to harm himself, I felt it was important that I ensured he was restrained effectively, and that's why I restrained the leg."

406. In the course of this incident DCO Donnelly said to D687 that: "*We'll wait for a minute until you pass out and then we'll cut you down. Nobody is dying today*".[620] In his evidence to the Inquiry, DCO Donnelly rightly accepted in questioning that he should not have said this to D687.[621] He explained that the reason he said it was:[622]

> "To point out the futility of him harming himself, bearing in mind that the ligature point was a foot and a half off the floor, so he wouldn't have been able to harm himself, and we were all there on hand to make sure that he didn't. I was trying to persuade him to give up the ligature."

407. That explanation is understandable – especially given the second sentence ("*Nobody is dying today*") appears to explained DCO Donnelly's motivations in saying the first sentence.

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[618] INQ000111_0057, para 223

[619] INQ000111_0060, para 236

[620] TRN0000095_0033

[621] Christopher Donnelly 23 February 2022 148/24-149/1

[622] Christopher Donnelly 23 February 2022 149/3-8; 149/21-23

Nevertheless, as DCO Donnelly accepted, that language was not appropriate in the circumstances and should not have been used, even if the intentions were to persuade D687 to give up the ligature.

408. There is a suggestion that in the course of the incident D687 sustained bruising to his ribs. There is no proper evidential basis for the Inquiry to make any finding that any such bruising was caused by officers acting improperly (should it even be considering doing so) – particularly given the inconsistencies in D687's account identified above and the absence of live evidence from D687. Mr Collier has offered the suggestion that "*The small area in which the incident occurred may have been a contributing factor in any impact related injuries*".[623] This is also consistent with the evidence of Nurse Parr that a bruised rib could be caused by knocking into a wall or door.[624] Mr Collier also saw "*no reason why handcuffs could not have been used on this occasion*".[625] In relation to that, "*The initial use of an inverted wrist hold (known in this circumstance as a back hammer) would be within training and is the approved way for transferring an arm to the rear for handcuffing*";[626] this was consistent with the technique applied by DCO Farrell.[627] The PSU was also clear in its conclusions that there was not any "*deliberate kick or punch to the left ribs*".[628]

409. Counsel for D687 has described this incident as "*a domestically unlawful use of force, an unjustifiable use of force into that mix on top of that, then that is the breach [of Article 3] and that is where it all absolutely goes over threshold with that final, slightly chaotic, thoughtless act, unplanned, as it were, by Duty Director Haughton*".[629] G4S respectfully disagrees. D687 was ultimately moved against his will against a history of non-compliance with transfers. The incident may have been distressing for him, but – in light of its resistance to transfer – that distress is, unfortunately, likely to be inherent for him in an unwanted transfer. At no time during the incident were any steps taken with the intention to degrade or humiliate. On the contrary, staff acted at all times with the intention of protecting D687's safety and dignity. There were discussions for 11 minutes before force was used, with Mr

[623] INQ000158_0047, para 19.0

[624] HOM002725_0046, para 7.5.38

[625] INQ000158_0047, para 19.0

[626] INQ000158_0047, para 19.2

[627] HOM002655_0002

[628] HOM002725_0046, para 7.5.38

[629] Closing Statements 5 April 2022 139/25-140/5

Collier praising staff for displaying a calm demeanour through this period, while attempting to resolve a difficult situation. Further, Mr Collier is generally positive about the application of techniques by staff once these were deployed, including the swift removal of restraints, which was a "*good example of de-escalation*".[630]

410. Where there is legitimate criticism of staff conduct in the course of this incident, it is not conduct which is to humiliate or degrade:

(a) First, there is criticism of a one-off comment by DCO Donnelly that: "*We'll wait for a minute until you pass out and then we'll cut you down. Nobody is dying today*". As explained above, DCO Donnelly regrets that language but, from context, its intention is clearly to seek to persuade D687 not to try and self-harm. It is not to humiliate but, on the contrary, to instil confidence that D687 would not be harmed: "*Nobody is dying today*". It should also be noted that this is one phrase used in the course of a protracted incident.

(b) Secondly, the key criticism concerns the conduct of Daniel Haughton. As set out above, G4S broadly accepts that criticism, although it is not the sort to render the use of force in breach of Article 3. It is not debasing or degrading, but primarily concerns whether Daniel Haughton should have spontaneously sought to bring the incident to a resolution by using the offer of the lighter to remove the ligature. Had he not done so and force was used instead on a 'planned' basis, there would have been clear benefits to this: not least the presence of healthcare and better coordination between officers. However, Daniel Haughton's actions, although it may be said that they caused some confusion amongst staff, can hardly be said to degrade the detained person. To the extent that it may be suggested that the 'subterfuge' of the offer of a lighter was inappropriate; although there is merit in Mr Collier's reasoning that not being straightforward with detained persons can undermine staff credibility in future incidents, nevertheless this does not come close to engaging Article 3 in circumstances where: Daniel Haughton took an operational decision, in the moment, on the basis of a dynamic risk assessment and acted at all times in what he considered to be the detained person's best interests (even if, in Mr Collier's view, it was the 'wrong' move to make in the moment).

[630] INQ000111_0058, para 225.

Row 17: Incidents on 13 May 2017 involving D232 and D1667 reacting (twice) to spice

411. This pair of incidents concern detained persons who were both taken to E wing for monitoring after experiencing reactions to spice; only then seemingly to smoke spice again on E wing.

412. Two points should be noted at the outset: first, there is very limited evidence before the Inquiry to make findings in relation to these incidents (e.g. neither were addressed in the Inquiry's oral hearings); and secondly, neither incident concern staff *mistreatment* of a detained person (whether through the use of force or otherwise). At their very highest, as explained below, the incidents could be said to demonstrate either that there were drugs present in E wing or that staff should have carried out 'rub-down' searches of D232 when he was taken to E wing, which *might* have identified further spice on his person.

413. Callum Tulley gives written evidence of these incidents:[631]

> "The following day there were two medical responses for two detainees, D232 and D1667 who both collapsed and suffered seizures apparently after smoking spice. During the medical response to D232 a member of the medical team and an A wing officer told me they felt it was only a matter of time before a detainee died as a consequence of spice. Both detainees were moved to E wing for monitoring, but still managed to smoke spice for a second time, prompting a further medical response. I made a note of this at page 17-18 of BBC00059 and it was captured on the undercover recording[632]."

414. G4S investigated these incidents. It stands by its conclusions which, it is submitted, are the best source of analysis in relation to the incident available to the Inquiry:[633]

(a) In relation to D232, he was seen by healthcare on E wing after reacting to spice. Fifteen minutes later he appeared intoxicated again; and the incident report indicates that he had a full search on E wing, but only after he appeared intoxicated for the second time. He had not been fully searched prior to these observations, although there was no intelligence [to suggest he would be in possession of spice]. G4S' conclusion was that in accordance with protocol, D232 should have been rub-down searched after he first showed signs of intoxication by spice. Protocol was thus not followed in this regard.

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[631] INQ000052_0059, para 223

[632] See KENCOV1016: V2017051300006: TRN0000095_9-17

[633] CJS000813_0012

(b) In relation to D1667, he suffered a seizure after having smoked spice and was taken to E wing for monitoring. There is a SIR referring to a search of D1667's cell on A wing after the medical emergency.

415. In addition, the Inquiry has the benefit of Callum Tulley's video diaries, providing his understanding of the incidents:[634]

(a) Callum Tulley suggests that D232 had been searched on his way in to E wing but, despite this, managed to smoke spice there: "*he was searched when entering the wing so either he managed to smuggle something [in] or there was already spice circulating around that wing*".

(b) It was in fact Callum Tulley who searched D1667 when he was brought down to E wing: "*I searched him just as I normally would, just as staff do in Brook House... He was found having another seizure on the wing, after smoking yet more spice. I mean, we search detainees but we don't do full searches. We don't do strip searches. There are certain places we can't touch or look, for obvious reasons.*"[635]

416. Accordingly there is something of a clash of evidence as between Callum Tulley's understanding and G4S' findings that D232 had only been fully searched after he appeared intoxicated with spice for the second time. It may be that G4S found no *documentary* evidence of D232 being searched on entry to E wing, which would explain why that search was not included in its report. It may be that the Inquiry feels that it is unable to resolve this clash of evidence, based on the limited information before it.

417. In any event, what is clear based on Callum Tulley's video diary is that even where 'rub down' searches were carried out, these are not strip searches and there still remain places where officers are unable to touch or look. Combining that point with the evidence heard by the Inquiry regarding the ease with which spice can be secreted (e.g. soaked in paper), it remains very probable that D232 and/or D1667 were able to bring spice with them to E wing, notwithstanding any searches that were – or, possibly in D232's case, should have been – carried out.

418. Unfortunately, given that ease with which spice can be hidden, and the understandable (and appropriate) limitation on searching powers, the operation of the IRC comes with a certain in-built risk that, if carefully secreted or hidden, not all spice would be discovered by staff,

[634] TRN0000050_0003-0005

[635] TRN0000050_0004-0005

even with regular and rigorous searching. Where detained persons bring spice into the Centre, or cause it to be brought in, staff make reasonable efforts in line with protocol to search for and confiscate it on an intelligence-led basis. Ultimately, however, the staff cannot be held responsible for the actions of detained persons, where they have knowingly imported spice into the centre. The SIRs on record demonstrated that D232 was a known drug user; there was intelligence that he had produced and sought to supply cannabis; and it was believed that he may have collected a parcel from Brook House reception containing spice.[636]

Row 18: John Connolly's language while D275 was on the netting

419. This incident occurred while D275 was protesting on the suicide netting. A team of Brook House staff were in the stairwell of a wing because only specially trained staff were permitted to enter the netting. As a result, the National Response Team (often referred to as 'the Nationals') had been called to intervene, and the Brook House team were on standby in case there was a risk to life before the Nationals arrived.[637] John Connolly was directing the staff in the team as to how the restraint would be carried out (if it was necessary).

420. The incident concerns the language and directions given by John Connolly in the stairwell (who was additionally a restraint trainer). It is important to note that accordingly the relevant detained person (D275) was not present when this conduct of concern took place; and, furthermore, the conduct under scrutiny did not involve any use of force, itself, but rather the concerning manner in which John Connolly provided instruction to the others within the team.

421. From the outset, G4S is absolutely clear that the language used by John Connolly was completely unacceptable. There can be little in dispute factually as to what occurred (although some particular aspects are disputed by John Connolly), given that this incident was captured by Callum Tulley's recording.[638] In his disciplinary outcome letter, Ben Saunders was right to observe that the footage had been drawn from a period of three hours

[636] See CJS005027_0003 and CJS004960_0001

[637] See INQ000052_0044, para 175.

[638] See, in particular, TRN0000085

in the stairwell;[639] however, from G4S' perspective, while that may provide some context to the incident, it in no way mitigates or justifies the language used by John Connolly.

422. From the lengthy period of time spent in the stairwell, the key concerning statements by John Connolly are as follows:

(a) "*Just say listen here n****r. Listen to me. Do what you are told, n****r*".[640]

(b) "*If he fucks up everything, he's getting [inaudible]. So watch his fucking - mash him up in the corner.*"[641]

(c) "*And then, if he refuses, [inaudible] we can shove him in there… That's our justification, right? We shove him in there - these stairs… That's our justification. We fucking throw him in that corner. You fucking deal with me. No fucking corner, eh?*".[642]

(d) "*If he's all right, just fucking walk him out. Walk him down this way. Throw him down the fucking stairs. Go for it*".[643]

423. It is right to note that John Connolly has since accepted that there is no excuse for the language that he used – particular in relation to the racial epithets.[644] However, he did deny making the statement at (d) above.[645] In relation to the comment at (c), he explained the 'justification as follows:[646]

> "If he started to become refractory on the top of the stairs, then we'd have to put him against the side of the wall and walk him down the stairs with his back to the wall, sideways, one officer on the bottom, pinning his arm, one officer on the top and one officer on the front."

424. G4S' position is that John Connolly's denials in relation to certain of these comments fall flat and the correct position is that reflected in the transcripts. John Connolly perhaps gave the game away in his oral evidence when he referred to "*may be trying to… convince myself,*

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[639] HOM001428_0001

[640] TRN0000085_0044. John Connolly originally appears to have denied saying this but did ultimately accept doing so: John Connolly 2 March 2022 188/19-25.

[641] TRN0000085_0054

[642] TRN0000085_0054

[643] TRN0000085_0055

[644] John Connolly 2 March 2022 190/5-6.

[645] John Connolly 2 March 2022 194/21-25.

[646] John Connolly 2 March 2022 198/7-12

I don't know".[647] He may not have recalled using those words, and perhaps his denials reflect his "*wishful thinking*" (in the words of CTI)[648] that he had not done so.

425. There is something of a dispute in relation to phrase "*I'll just grab – just grab the c**t*", which is attributed on the transcript to Dan Small but which was also said by John Connolly.[649] Dan Small had pointed the existence of a camera out to John Connolly and the suggestion is that John Connolly had not said "*grab*" the 'c**t' (referring to the camera), but had in fact said "*scrub*" – i.e. suggesting that he would delete any relevant video footage. John Connolly denied saying or suggesting this on the basis both that: "*there is no way, technically, I could wipe CCTV footage*" and that Dan Small and Callum Tulley had worked in the control room and so would know this.[650] Dan Small could not assist the Inquiry as he was not aware of the meaning of 'scrub' in that context;[651] but Callum Tulley's "*clearly*" heard it as 'scrub'.[652] Although there is a clash of evidence on this, G4S submits that on this instance Callum Tulley's account is to be preferred: it is consistent with the footage and the context of the conversation and was also the conclusion reached by Ben Saunders: "*This appears to be consistent with the allegation and I believe this to be your voice and referring to camera footage. Although I am not certain how you would tamper with camera footage, I do believe you to have said this and given your colleagues the impression that you were able to do this*".[653] John Connolly's explanation that both Dan Small and Callum Tulley would have known that he was not able to wipe CCTV footage is not convincing against a backdrop where, in this situation, he was the experienced officer (and trainer); and the context points to a dynamic in which he was posturing himself as full of bravado.

426. Quite rightly, Ben Saunders considered John Connolly's conduct to amount to gross misconduct and summarily dismissed him.[654] It is right to observe that Dan Small was also given a written warning for this incident.[655] The charges put to Dan Small concerned: (a) his actions on 17 May 2017, including pointing out a camera to John Connolly when

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[647] John Connolly 2 March 2022 189/7-9

[648] John Connolly 2 March 2022 189/8-10

[649] TRN0000085_0054

[650] John Connolly 2 March 2022 194/3-17

[651] Daniel Small 28 February 2022 162/13-17

[652] Callum Tulley 2 December 2021 55/1-15

[653] HOM001428_0002

[654] HOM001428_0002

[655] CJS006639

discussing assaulting a detained person in the stairwell; and (b) not reporting the wrongdoing of John Connolly discussing assaulting a detained person if brought to the stairwell. Sarah Newland's findings were that in relation to the former matter, "*you were aware of the camera and challenged your colleague by pointing this out*".[656] That is consistent with how the matter was put to John Connolly:[657]

> "But one suggestion is, and this is a suggestion by Callum Tulley, and it is a combination of what he has had to say and what Dan Small has had to tell us, is that Small was so concerned about what you were saying that he wanted you to stop, and one way he tried to get you to stop saying what you were saying was to indicate or gesture up to a camera on the wall in the hope that you would pipe down".

427. Accordingly, of the charges brought against Dan Small he was not disciplined for the former, but only for the latter – namely that he should have, but did not, report the incident.[658] That conclusion is reflective of G4S' expectation that its staff reporting wrongdoing of their colleagues; and in fact *disincentivise* any reluctance to report or 'grass' through disciplinary action, such as this.

428. Finally, out of fairness to John Connolly, it is right to point out the consistent theme of evidence heard by the Inquiry that – atrocious as it was – the use of racist language was deeply out of character. Callum Tulley told the Inquiry that: "*The N word wasn't a word that was used typically. No, that wasn't commonplace, sir. Anti-immigration rhetoric was commonplace, but such racist language wasn't.*"[659] It also surprised, amongst others, Chris Donnelly;[660] Yan Paschali;[661] and Clayton Fraser.[662]

429. Similarly, this is not an incident that can rightly be said to amount to a breach of D275's Article 3 rights. Yan Paschali described John Connolly as "*just sounding off*"[663] – something that he would do in front of colleagues out of possibly frustration or bravado; but the point is that these comments: (a) did not lead to any force or mistreatment to D275 in the manner

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[656] CJS006639_0001

[657] John Connolly 2 March 2022 193/1-9

[658] See further CJS006639_0001

[659] Callum Tulley 2 December 2021 46/21-23

[660] Christopher Donnelly 23 February 2022 90/4-22

[661] Yan Paschali 24 February 2022 25/6-26/1

[662] Clayton Fraser 28 February 2022 5/24-6/8

[663] Yan Paschali 24 February 2022 25 26/13

described therein (or at all); and (b) were not made to, or in the presence of, D275. There was no intention that the comments or their content be reported to him. That does not make them acceptable; far from it. However, it is a far cry from the forms of misconduct found to have breached Article 3, where the relevant mistreatment is aimed directly at the victim – not inappropriate comments between colleagues, not in earshot of the detained person.

Row 19: Use of force against D2034 by DCO Kye Clarke

430. This incident involves the threat by D2034 to self-harm and the repeated climbing by D2034 on and off the suicide netting. The gravamen of the incident was the solo action taken by DCO Kye Clarke, sensing an opportunity to pull D2034 away from the netting and doing so. There are two aspects to the incident in particular: first the proactive decision by DCO Clarke to try and restrain D2034 in an unorthodox manner, and without specific authorisation from another officer; as well as the manner in which DCO Clarke did so – leaving a door unlocked and depositing his shoes, keys and utility belt. The latter is an important security issue for the IRC, but is likely to be of less concern to the Inquiry than questions around the actual use of force, itself.

431. DCO Clarke's account of the incident is as follows:[664]

> "The detainee had climbed onto the wire safety netting and was threatening to self-harm by cutting himself. His roommates told me that he had taken his razor apart that morning and was threatening to cut his wrists if he was not released from the detention centre. The detainee would periodically come down from the netting but if the DCOs approached him he would climb back on again. This happened on about six or seven occasions. On one occasion when the detainee had climbed off the netting, I travelled up the backstairs and I was able to physically restrain him. To do this I had to remove my belt with my keys so that he couldn't hear me coming. I managed to take hold of the detainee as he attempted to climb back on the netting and pulled him backwards towards me, so that the detainee landed on top of me."

432. In relation to the removal of his shoes and keys in particular, he explained in the course of his disciplinary investigation that:[665]

> "I still had my stuff on and was watching from a small gap in the door and could see him pacing, another officer moved away from him. He was raising his voice and raising his arms on the railings — my key chain rattled the door and he looked my way, so he knew I was there, so I took my belt

[664] INN000012_0017, para 69; see also CJS005618_0009-0010

[665] CJS0073535_0001-0002

> off which I know now I shouldn't… Yes, I know it was a key breach I was just trying to make as little noise as possible. I waited for him to move and as I watched he walked round the back to the far end of the landing and he jumped over to the landing side. I took my shoes off as they are quite slippery; if I had to grab him quick then I wouldn't slip. At this point he was checking his arm and he had a small red mark on it — I'm sure his body then flinched as if he was going to jump back on. So as I opened up the door I ran towards him and put my arms around him and my legs around his waist and pushed my foot onto the railing and he fell onto me, he couldn't get his arms free and said I can't move."

433. As DCO Clarke explains, he was suspended pending an investigation both for taking off his belt and keys, as well as for "*restraining a detainee without the assistance of two colleagues*".[666] He resigned from the Company before the disciplinary process could run its course.

434. Before DCO Clarke became involved, Mr Collier refers to DCO Murphy's attempts to engage with D2034 and, together with another officer, attempted to grab D2034 and pull him back from the netting (during which DCO Murphy injured himself).[667] Mr Collier points out that that these attempts were in line with guidance.[668]

435. The key area for criticism, therefore, concerns the conduct of DCO Clarke. As to that:

    (a) Mr Collier rightly observes that staff are expected to remove their utility belt (which includes keys, radio and emergency aid kit) in sterile areas; certainly not residential wings.[669]

    (b) DCO Clarke swiftly moved over, taking D2034 by surprise using a 'rear takedown technique', for which there is no training in the Use of Force syllabus (although that latter point does not necessarily render it unlawful). DCO Clarke controlled D2034 on the ground until colleagues arrive, following which they stand D2034 up and use guiding holds to move him from the wing.[670]

436. Mr Collier's primary concern is the fact that this manoeuvre was carried out by DCO Clarke alone, without the assistance or authorisation of others. As Mr Collier explains:[671]

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[666] INN000012_0018, para 72

[667] INQ000111_0108, para 450

[668] INQ000111_0100, para 458

[669] INQ000111_0108, para 452

[670] INQ000111_0109, para 453; INQ000111_0110, para 461

[671] INQ000111_0109, para 454

> "If this method of intervening and resolving the situation was planned and authorised by the duty direction I would state it was well executed and achieved its aim with no recorded injuries. The intervention did prevent the incident becoming protracted and prevented any self-harm or damage to the structure of the netting."

437. Further, commenting on the actual force used:[672]

> "It was necessary to prevent D2034 going on the netting, the force was reasonable, in that he applied a takedown technique that did not put D2034 at risk, and was proportionate due to once he made contact he quickly removed his control and used the lowest level restraint, guiding holds to move and prevent D2034 from jumping back on the netting".

438. The problem with DCO Clarke's actions were therefore: (a) that he left his utility belt unattended, which is a security breach; and (b) that he acted alone – without assistance or authorisation. It is fair to say that the actual technique deployed by DCO Clarke is, in fact, praised by Mr Collier – but the overall problem was that he should not have gone on a frolic of his own in this way: the incident should have been dealt with as a planned use of force, authorised by a supervisor and with at least 3 members of staff in attendance. What DCO Clarke did, in essence, was to spot an opportunity to resolve the situation alone; and to seek to take it.

439. In fact, he did so, but without proper authorisation and assistance, the use of correct technique and successful outcome can perhaps be described as 'lucky'. The police's view was that, while DCO Clarke may have breached G4S internal policies, he "*clearly also used minimal, justifiable and necessary force, to prevent the detainee either from injuring himself or others*".[673]

440. In short, therefore, this incident discloses an important security breach in the form of DCO Clarke's temporary disposal of his utility belt and keys in an area where it was accessible to detained persons and not accessible to himself. It also includes poor conduct in the form of DCO Clarke taking the initiative and seeking to resolve the situation alone, through the use of a technique that had not been taught. As Mr Collier explains, however, the technique and its execution were appropriate – but DCO Clarke should not have acted alone and without formal authorisation. The telling phrase in Mr Collier's report was essentially that if the same use of force had been formally authorised and planned, he would have stated that it

[672] INQ000111_0109, para 455

[673] SXP000039_0004

was "*well executed and achieved its aim with no recorded injuries*".[674] From D2034's perspective, therefore, he was the subject of a use of force which is properly executed and without causing him harm. Of course he was not to know about the formalities of authorisation, but the very fact that the use of force was proportionate and safely executed – and carried out to prevent harm to D2034 – makes clear that the formality of the 'authorisation issue' cannot alone render this incident a breach of Article 3.

Row 20: Use of force against D52 on 22 May 2017

441. This is an incident in respect of which Mr Collier changed his mind. His initial conclusion (before he had access to the BWVC) was that: "*All efforts appear to have been made for a peaceful resolution, so I am satisfied the decision to use force was the last option available*".[675] It was in this respect – in relation to the question of whether force was used as a last resort – that his view changed, having considered the video footage.[676] In light of the footage, his view was that: "*at the point (07:03) force was initiated it was not the last resort and the UOF was not necessary at the time*".[677] He summarised his view neatly when giving oral evidence:[678]

> "There was, on the face of it, a very simple solution to this whole incident, which was to escort D52 to his room to collect his belongings, or at least stay there while staff assisted him to collect his belongings. That would have, on the face of it, been a simple solution. It was mutually agreed by both parties, which would have avoided force being used."

442. This incident concerned what DCM Aldis described as "*a difficult restraint with a resistant detainee in a confined space*".[679] The difficulty is made plain by the fact that during the course of the restraint, D52 bit DCO Marshall.[680] In his original report, and against that backdrop, Mr Collier made no criticism of the particular techniques and their application, noting that: "*Handcuffs were applied and restraints removed once under control. Description of using a knee to pin the arm would be a reasonable UOF as long as it was*

[674] INQ000111_0109, para 454

[675] INQ000111_0091, para 367.

[676] UOF 129.17 BWC.MOV

[677] INQ000177_0006, para 20

[678] Jonathan Collier 30 March 2022 164/8-14

[679] INQ000181_0018, para 88(e)

[680] CJS005620_0011

only for the required time and removed once control was achieved".[681] He does not appear to demur from this position in his second supplementary report, in which the nub of his view was that (in light of the footage): "*When force is initiated, it was not when all reasonable efforts had been made and there was no reason for force at that stage*".[682]

443. In light of Mr Collier's focused criticisms – chiefly that force was not necessary in the circumstances and that further efforts should have been made to negotiate with D52, two central issues arise for the Inquiry's consideration: (a) was the use of force necessary; and (b) was there deliberate obstruction of the BWVC?

444. First, in respect of the necessity of the use of force, Mr Collier's view is based on the fact that force was initiated after approximately 7 minutes of discussion; his view that the use of force could potentially have been avoided if D52 had been escorted to his room to collect his belongings; as well as the fact that D52 was not being handed over to the escort staff until the next day (as compared to incidents where there was an imminent deadline to meet a flight).[683]

445. G4S respectfully points out that Mr Collier makes a number of these observations without grappling with some of the countervailing considerations, such that ultimately the Inquiry cannot confidently rely upon his view that force was not necessary in the circumstances (especially as he cannot give underlying factual evidence) and does not address the relevant factual evidence that post-dates his second supplementary report (e.g. the witness evidence of David Aldis[684] or Dean Brackenridge[685]).

446. Taking some of Mr Collier's points in turn:

    (a) A view had clearly been taken that notwithstanding that D52's transfer was the next day, it was nevertheless appropriate for his initial 'interim' transfer to E wing to occur on 22 May 2017. Importantly, the reason for that 'interim' transfer was, as DCM Aldis explains because D52 had: "*stated that, under no circumstances, would he leave the UK and that he would cause problems for the Home Office*".[686] Mr Collier simply

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[681] INQ000111_0091, para 368

[682] INQ000177_0007, para 24

[683] See above and, in particular, INQ000177_0008, para 27.

[684] INQ000181 and INQ000197

[685] BDP00006

[686] INQ000181_0018, para 88(a); see also BDP00006_0008, para 23

assumes, but without a stated basis, that there was not an operational need to move D52 to E wing that day. He was not in a position to make such an assumption.

(b) In DCO Marshall's account,[687] he clearly explained D52's assertion that he would only go to C wing – suggesting that, Mr Collier's suggestion that the need for force would have been averted, if only officers had accompanied D52 to get his belongings was naïve. That aligns with D52's previous statements about a refusal to leave the UK (see above).

(c) In the context of D52's remonstrations, "*aggressive behaviour*",[688] "*earlier threats*" and becoming "*more agitated*"[689] force was used. The footage reviewed by Mr Collier is not wholly clear and DCM Brackenridge's evidence is that "*as the officers moved towards D52, he began lashing out, and force had to be used*".[690]

447. Accordingly, therefore, Mr Collier does not deal with the evidence that force was used in response to D52 lashing out and acting aggressively towards officers. That is also pertinent to his criticism that 7 minutes was not necessarily sufficient time to explore all avenues for voluntary compliance. Respectfully, in the context of a live incident, 7 minutes was quite a substantial period of time before the application of force, particularly where staff had made repeated attempts to de-escalate over that period of time, which were met with only increasing agitation from D52.[691] It is respectfully submitted, therefore, that in the context of: (a) D52's agitation and aggression; (b) his earlier threats, which suggested he took issue with more substantially more than just wanting to get his belongings from C wing; and (c) the operational decision that had been taken that there was a need to move D52 to E wing that day – Mr Collier's criticisms in this regard are misplaced, and that they (in some senses understandably, given that his second supplementary report pre-dates some of the witness evidence) do not grapple with the totality of the evidential picture.

448. Secondly, in relation to the obstruction of the BWVC, in the witness box Mr Collier stated that "*the only thing I can think of was that someone has deliberately covered the camera*".[692] Mr Collier does not explain why he came to a different view in his second supplementary

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[687] CJS005620_0010

[688] CJS005620_0010

[689] INQ000181_0018, para 88(d)

[690] BDP00006_0008, para 23

[691] See INQ000181_0018, para 88(c)

[692] Jonathan Collier 30 March 2022 166/2-11

report ("*The hands over the lens could have been accidental but it is unclear who is actually operating the camera*"),[693] especially as he does not refer to any new material not available to him when compiling the second supplementary report. More than that, there was new material available to Mr Collier since he completed that report – namely the witness evidence of DCMs Brackenridge and Aldis. Both give evidence on this issue, with which Mr Collier does not engage at all. Indeed, it would appear that Mr Collier has not considered their evidence, as his oral evidence on 30 March appears to assume that there was one camera operator ("*You can see that the person that was in operation of the camera wasn't part of the restraint*").[694] However, it is clear that the camera changed hands multiple times: DCM Brackenridge first explains that: "*As soon as D52 became compliant I released control of his legs and took control of the body-worn camera. As the detainee is walked out of the room the footage shows me handing the camera over to someone called Jim*".[695] DCM Aldis added in his second statement (admittedly after Mr Collier gave oral evidence) that: "*It appears that I was wearing the body worn camera up until around 8.49. I then hand it to another colleague. This may have been DCM Brackenridge but I cannot be sure*".[696] Their evidence adds further details not considered by Mr Collier. For example:

(a) DCM Aldis explains that: "*during the relevant period, the cameras had twistable heads. The head of the camera may have twisted when I passed it to a colleague.*"[697] He adds that:[698]

> "During the relevant period, there was a limited number of body worn cameras and, therefore, not every DCM had one. Although I cannot recall the incident, I probably handed the camera to a colleague who was less likely to be involved in the incident. This would enable them to video the incident much clearer than me."

(b) DCM Brackenridge further explains:[699]

> "Having reviewed the footage, it is clear to me that I turned the camera towards me and, having realised the angle was off, I twisted it so that it was facing the right way. In doing so my hand obscured the lens for a few

[693] INQ000177_0007, para 26

[694] Jonathan Collier 30 March 2022 166/6-8

[695] BDP00006_0009, para 24

[696] INQ000197_0001, para 1(a)

[697] INQ000197_0001, para 1(b)

[698] INQ000197_0001, para 1(c)

[699] BDP00006_0009, para 25

> seconds. You can see from the footage that the officers were in exactly the same position immediately before and after the few seconds when the lens was covered".

449. As such, the circumstances surrounding the operation of the camera are – at best – far from clear. It does appear, though, that the camera was passed between operators and, given its twisting head, it is more than likely that it may have inadvertently been turned around on one or more of these occasions, accidentally obscuring D52 from view. Certainly, though, there is no evidence from any factual witness suggesting that the camera was at any point deliberately covered. For those reasons, it is respectfully submitted that the Inquiry should not accept Mr Collier's suggestion that there was deliberate covering of the camera.

450. Finally, it is right to point out that this incident cannot be said to amount to a breach of Article 3 (or even close to it), where serious attempts at de-escalation were made for 7 minutes, and which were met with increasing agitation and aggression from the detained person. Even putting aside the critiques of Mr Collier's position set out above, even if his view were accepted in full, the high Article 3 bar would not be met merely by the decision not to *prolong* the discussions with D52 to try and avoid the need for force to be used – particularly where there is evidence that the detained person had made clear his opposition to removal and had made concomitant threats to those involved in the process.

Row 21: Use of force against D1978 on 23 May 2017

451. From Mr Collier's perspective, the use of force against D1978 on 23 May 2017 was, in many respects, a textbook example of how staff are expected to conduct themselves during such an incident. That is certainly true; particularly in respect of those DCOs and healthcare staff involved in conducting and observing the use of force. That is subject to one important caveat, addressed below.

452. Before dealing with that, however, it is right to alight upon the well-deserved praise for how staff conducted this use of force, as given by Mr Collier:[700]

    (a) The context for this use of force was that D1978 had made threats to staff; spat at a DCO; and pushed a detainee down a flight of stairs.[701] On route to the CSU D1978

[700] See, in particular, INQ000111_0092-0098; also CJS005646

[701] INQ000111_0092, para 372

continued to verbally abuse staff, spat at DCM Dix and made racist comments towards a member of the healthcare team ("*black witch*").[702]

(b) The activation of a BWVC sets out "*good practice*".[703]

(c) DCM Dix provided a briefing to staff in advance of the use of force and the staff accounts of the incident are confirmed by the BWVC footage. Indeed:[704]

> "after the initial contact is made by DCO Sayers the shield is removed and staff applying controlling techniques as described in the UOF training manual. All of the procedures carried out were in fact textbook examples of a planned intervention, including use of BWVC, healthcare in attendance and de-escalation used. There was a swift move out of the room and after moving off the wing into a corridor D1978 is allowed to stand upright"

(d) "*The relocation into the CSU room was again a good example of using only the necessary level of force, staff released the controlling holds and allowed D978 to walk into the room*".[705]

(e) Mr Collier also explained:[706]

> "Throughout this removal all of the staff demonstrated the utmost professionalism and self-control when faced with a very challenging individual. The constant verbal abuse and personal threats did not generate a response and the staff carried on with their duties without responding to the attempts at intimidating them."

(f) In relation to the actual restraint used on D1978, Mr Collier observed that "*D1978 does not appear to be in any pain and the restrain holds are consistent with the approved method*".[707]

(g) Mr Collier also refers to footage from Callum Tulley's covert records which captured "*intimidating*" behaviour by D1978;[708] talk of D1978 spitting towards a DCO;[709] and

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[702] INQ000111_0092, para 374; INQ000111_0093, para 378

[703] INQ000111_0092, para 376

[704] INQ000111_0093, para 377

[705] INQ000111_0093, para 378

[706] INQ000111_0093, para 379

[707] INQ000111_0094, para 382

[708] INQ000111_0095, para 386

[709] INQ000111_0095, para 387

D1978 "*being confrontational with staff, which along with other footage provides give full justification for the ultimate decision to locate him in the CSU*".[710]

(h) Overall, Mr Collier described the planned removal has having been "*carried out professionally and fully justified based on the events earlier in the day*";[711] and noted that "*in the face of excessive intimidation the staff all remained professional and should be complimented on their actions.*"[712]

453. All of those above points are true and are key takeaways from the incident. G4S does recognise, as Mr Collier did, that they are subject to one caveat in respect of the conduct of DCM Dix, in particular. It is best seen in the video footage.[713] At the door to D1978's room, DCM Dix (rightly) tells D1978: "*if you're not going to come, then [inaudible] will force you to go. So you've got one chance to come out now and walk: yes or no?...Come on...*" At that point, D1978 started to move towards the door to his room (which, it seems was not visible to the officers behind DCM Dix), in response to which DCM turned his body 90 degrees, opening up the doorway. That movement by DCM Dix may have been (as is likely) to permit D1978 to walk out of them – as it looks as though he may have done; although to those officers behind DCM Dix, it may well have appeared that he was opening the doorway space to permit them to enter and restrain D1978 – which is what they did. As they rush past DCM Dix to enter, he says to them "*no, no*" (although it is unclear whether they would have heard him through their PPE as DCM Dix's utterances were quiet); but they continue into the room, where the restrain of D1978 takes place (as set out in Mr Collier's report).

454. Mr Collier observes in relation to this as follows:[714]

> "As D1978 walks toward the door DCM Dix steps to the side as if to allow him to come out as directed. At this point the staff move in and restrain D1978 DCM Dix makes a belated move to stop them and can be heard uttering quietly no on more than one occasion. If D1978 was compliant and following the Instruction given to him using force would be unlawful in the circumstances. The correct procedure for a resolution would have been for DCM Dix to direct the shield officer to the door and to instruct D1978 to show his hands and walk toward the shield. He would then be moved from the room and face the wall before proceeding with moving to the CSU without force being used, unless handcuffs had been agreed for use."

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[710] INQ000111_0096, para 389

[711] INQ000111_0096, para 390

[712] INQ000111_0096, para 391

[713] Disk 48 20170523210142_E1506N_0013

[714] INQ000111_0094, para 381

455. Mr Collier also correctly observes that:[715]

> "The footage from the debrief provides a different version of events when described by DCM Dix as compared to what actually happened. During the debrief he states D1978 started to encroach toward him and he had no option but to deploy the team. The scene footage clearly shows DCM Dix stand aside to allow D1978 to leave the room and then the team move in and restrain D1978. DCM Dix makes a half-hearted attempt to stop staff but only after the first DCO has entered the room. DCM Dix utters quietly to himself no, no, no'."

456. These matters were put to DCM Dix when questioned by CTI. His answers in relation to his actions in the moment were candid and humble. His evidence was that:

(a) He wished he had waited to give D1978 an opportunity to responds to his 'yes or no' question;[716] and

(b) He agreed that from the footage it looked like D1978 was going to comply and that he (DCM Dix) had made a mistake and was trying to stop the other officers from entering by saying "*no, no, no*".[717]

457. That was DCM Dix rightly accepting that he should have given D1978 a clear opportunity to respond to his question and, in any event, since he appeared to be complying, once the other officers were moving in, rather than just saying 'no, no, no', he should have acted more assertively to stop them.

458. In relation to why in the debrief he had stated that D1978 had started to encroach towards him, leaving no option but to go in – DCM Dix again accepted that this was a mistake.[718] He was right to do so – as that remark did not accord with D1978's possible compliance. DCM Dix's explanation for why this mistake had occurred was that:[719]

> "All I can say is, obviously, at the time, you know, a debrief was done straight after the event. It had been quite a difficult removal. You know, he was abusive, threatening families, making racist remarks, I've been insulted, I've been spat in the face, and my memory probably was focused on the actual use of force rather than the beginning."

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[715] INQ000111_0095, para 384

[716] Steve Dix 9 March 2022 70/11-13

[717] Steve Dix 9 March 2022 70/25-71/4

[718] Steve Dix 9 March 2022 71/20

[719] Steve Dix 9 March 2022 71/20-7222

459. He did not agree that he had (deliberately) lied, but rather that what he had said in the debrief had been a mistake that slipped his mind, especially given the high adrenaline immediately after an incident of that nature.[720]

460. G4S invites the Inquiry to accept Mr Dix's explanation – particular recognition of the reality that "*sometimes you're going to miss things, sometimes you make mistakes*"[721] where this was one small remark in a debrief which followed a stressful restraint, during which the detained person had been abusive towards staff, including spitting at DCM Dix, himself. DCM Dix's honesty and humility in relation to what had occurred at the entrance to D1978's room further supports the suggestion that this was a genuine mistake during the debrief – one that he swiftly held his hands up to.

461. Mr Collier makes the point that the use of force in the course of this incident was not 'necessary' or the 'last resort' given the confusion surrounding whether D1978 was actually complying by walking out of his room.[722] G4S accepts that if D1978 would have complied for the duration of the transfer, then it stands to reason that the use of force could have been avoided. However, it invites the Inquiry to take a realistic and pragmatic approach to the incident. One need not deal in hypotheticals when one has the established facts than in the course of his transfer to the CSU, D1978 was abusive towards staff, spat at DCM Dix and racially harassed a member of the healthcare team. Even if he appeared to comply at first; indeed, even if he actually complied in the first instance, in light of his established abusive conduct – both before the incident and during his transfer, it is a virtual certainty that force would have been used as part of the transfer to the CSU – likely for the majority of it. Accordingly, while it is right that DCM Dix did not properly manage the scene at the start, it is unlikely that his error would have made any real difference to who the incident played out.

Rows 22 and 23: Use of force against D1914 on 27 May 2017 & demonstration of shield technique

462. This incident – the relocation of D1914 to E wing in advance of a removal flight to Romania is best addressed by dealing with the particularly criticisms/concerns raised by Mr Collier in relation to it:

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[720] Steve Dix 9 March 2022 72/15-21

[721] Steve Dix 9 March 2022 74/1-3

[722] INQ000111_0097, paras 398-399

463. These are four-fold:

464. First, Mr Collier is concerned why "it was decided for full PPE be issued for this incident. The fact that it is a planned removal does not automatically result in PPE being issued, each situation should be individually risk assessed and a decision made if PPE is appropriate".[723] This is a point of principle – as Mr Collier raises various concerns in relation to this incident which relate to: (a) the wearing of full PPE from the outset; and (b) particular points in time at which some or all PPE could have been removed. Mr Collier also gives as his point of reference/authority Prison Service Order 1600 ("**PSO 1600**"), suggesting that it provides that "the provision of PPE is optional".[724] With respect to Mr Collier, G4S submits that he is in fact factually incorrect on this particular point. He refers to paragraph 4.34 (sub-heading 'Role of the Supervising Officer') of PSO 1600 – but that says nothing about PPE being optional. Instead, paragraph 4.35 refers to further details of the supervising officer role being found in Annex F. Annex F then states:

> "It is recommended that all staff are provided with, and wear, protective equipment in a planned C&R incident. Protective equipment that should be worn is detailed below:
> - Short shield / mini shield (may be carried by the number 1)
> - Helmets
> - Shin / knee guards
> - Forearm guards
> - Gloves
> - Flame retardant overalls (if required)"

465. There is no suggestion in Annex F that any of these items are optional or should be removed at any time. On the contrary, the clear suggestion is that all these items (save for flame-retardant overalls, depending on the circumstances), should be provided to all staff participating in the use of force; and that they should be worn.

466. Accordingly, G4S respectfully submits that no criticism can legitimately be made of staff wearing – and not removing – PPE, including helmets: they were acting in accordance with PSO 1600. To the extent that Mr Collier considers that it would be preferable for the wearing of some or all PPE for planned uses of force to be considered on a case-by-case basis, that may be his professional opinion, although it should be recognised that it would require amendment of PSO 1600.

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[723] INQ000111_0032, para 115

[724] INQ000111_0030, para 101

467. Secondly, Mr Collier notes that: "*as a non-medical person I observed in my opinion was an unwell man being reluctant to move*".[725] As a result, he considered that more time should have been taken to sit him down and to try and explain the situation. Again, with respect, Mr Collier is not an medical expert; and quite rightly accepts this. In the circumstances, it was entirely appropriate for the custodial officers and manager to take their lead on medical matters from the doctor who had assessed D1914 and the healthcare staff who were present. It would not be right for them to impose their own conceptions of D1914's medical condition – particularly here as the use of force had been planned and healthcare staff were part of the wider process.

468. When one considers the underlying documentation, G4S staff took the appropriate approach. When they discovered that D1914 was due to be transferred, they raised concerns regarding his medical condition with the Home Office, both to ensure that TASCOR were aware of D1914's condition as well as to inform the Home Office that G4S would have a doctor assess D1914 before his removal.[726] Dr Oozeerally assessed D1914 and confirmed that: "*I am happy for reasonable force to be used (C and R) in order to facilitate the removal*".[727] From the perspective of the officers undertaking the transfer: (a) there was medical authorisation for reasonable force to be used in the transfer; and (b) healthcare staff were present should there be any complications. Mr Collier's implicit suggestion that a different threshold be applied for detained persons with medical conditions carries its own substantial risks – in particular placing an unfair burden on custodial staff to take into account medical assessments that they cannot properly make. Rather, if, for example, in light of a detained person's medical condition, force could only be used to prevent serious harm or death – that is something that the doctor should note on the 'authorising' letter. It is not an assessment for custodial staff to make.

469. In light of this, Mr Collier suggests that "*more efforts should have been made to gain compliance*" from D1914 and thus force was not necessarily the last resort.[728] On viewing the footage,[729] it is right to observe first that before any force is used, the healthcare team are given a full 5 minutes to assess D1914 again, at the invitation and instigation of DCM

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[725] INQ000111_0032, para 116

[726] HOM010972_0004

[727] CJS001160

[728] INQ000111_0033, para 116

[729] Disk 50 UOF 134.17 CAM 3

Dix. Next, once that assessment is complete and the healthcare staff are content to continue with the transfer, DCM Dix clearly informs D1914 that he is being transferred to E wing and that if he did not go voluntarily, the officers present would assist him. He then asked D1914 in clear terms if he would walk compliantly; to which D1914 responded in an equally clear negative. G4S accepts that, on its own, this does not appear to be a lengthy negotiation with D1914. However, one has to take into consideration two further factors: first, during the previous five minutes while D1914 was being assessed by healthcare staff, he made it clear that he was unwilling to comply with any transfer. Furthermore, DCM Dix's use of force report explains that earlier that day he and DCO Sean Sayers had "*negotiat[ed]*' with D1914, who refused to agree to comply and walk compliantly.[730] As such, the final question before locks are applied was not a reflection of the sum total of the discussion, but rather the culmination of a lengthier process and is better described as giving D1914 a final opportunity to comply or to make clear his refusal to do so – particularly in light of the earlier negotiations that had taken place that day. It is also right to note DCM Dix's evidence that D1914 "*could also be very aggressive and volatile*" – a point which he raised in his briefing, and was a relevant factor in the wider risk assessment as to the appropriateness of the use of force.[731]

470. Thirdly, in his first supplementary report, Mr Collier opined that:[732]

> "I have reviewed the debrief once more and on reflection feel it lacked depth into the force used. DCM Dix did give a narrative of the sequence of events but did not ask the staff involved for any contribution other than if they had any injuries. There is reference to D1914 being resistant to start but he then co-operated with staff. Ideally DCM Dix would have outlined his decision making and how the incident was de-escalated. Healthcare contributed very little, and it almost felt that the urgency was to get back to their duties. I accept this was 'hot debrief' and that there may have been a follow up debrief but based on the evidence presented so far this does not appear to be commonplace within the centre."

471. G4S accepts this as valid constructive criticism into the conduct of the debrief after the incident.

472. Finally, Mr Collier criticises the description given to staff regarding how the shield was to be used: it was "*incorrect and appeared to imply that staff use the bottom edge to deliberately target specific areas of the body with the shield edge. Correct training is for a 45 degree angle initially*

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[730] CJS005981_0013

[731] Steve Dix 9 March 2022 80/20-25, 82/18-20

[732] INQ000158_0019-0020, para 4.4

before covering the torso and any weapon arm, if applicable".[733] G4S agrees with this criticism. There is no suggestion that any officer in the course of this incident in fact *used* any incorrect technique, but that does not excuse David Webb providing improper instructions to Callum Tulley in the manner that he did ("*hit with the edge anywhere between the knee and the throat… and then just keep fucking going*").[734] That has been G4S' consistent position:

(a) it suspended David Webb as a precautionary measure when the matter came to light;[735]

(b) it substantiated that allegation against David Webb when the matter was investigated – with David Webb accepting that they were "*unprofessional and inappropriate*"; and thus referred the matter to the Commissioning Authority (i.e. the Home Office);[736]

(c) it disciplined David Webb for having done so – issuing him with a verbal warning;[737]

Row 24: Use of force against D149 on 31 May 2017

473. This incident concerns the transfer of D149 to the CSU on 31 May 2017 following him having sought to grab Callum Tulley's keys earlier that day. It is an incident in relation to which Mr Collier has a number of comments and points of concern, which are addressed in turn below. In short, G4S' submissions in respect of this incident is that *overall* the use of force was necessary and proportionate, including the choice of techniques used in the transfer. However, it does accept Mr Collier's criticisms in relation to the technical application of some of those techniques in the situation.

474. As a starting point, and as a legitimate point of 'mitigation' in respect of any technical errors made by staff in applying control and restraint techniques on D149, this was a difficult transfer in respect of an abusive and at times violent detained person. Callum Tulley described it as a "*messy restraint*", which he explained in oral evidence to mean that "*[D149] had fought all the way to the block*".[738] That is a particularly important consideration in

[733] INQ000111_0033, para 117; see also INQ000158_0019, para 4.2

[734] TRN0000098_0015

[735] HOM001112

[736] CJS005979_0008, 0011. David Webb also accepted that Mr Collier was correct about the appropriate technique and that his own expression had been poor: David Webb 3 March 2022 138/15-140/19.

[737] HOM001116_0001

[738] Callum Tulley 9 March 2022 128/12-13

circumstances where, as is submitted below, the primary concerns of Mr Collier concern the application of techniques 'in the heat of the moment'. The Inquiry should be mindful of the operational pressures of a live C&R situation, where – notwithstanding advanced planning – officers are responding spontaneously to unexpected developments and a dynamic situation. In those circumstances, there will, on occasion, be situations where the deployment of techniques does not always go to plan, or, for example, the resistant actions of a refractory detained person cause locks or restraints to be applied in a manner other than the 'textbook' approach.

475. In his first report, Mr Collier pointed out a number of important aspects of the incident:

(a) D149 made repeated attempts to kick, knee and trip staff during the removal; and was verbally abusive towards them, including the healthcare nurse. During the incident he said: "*I will kill you*" to staff.[739] Staff accounts in their reports of the level of resistance and abuse from D149 was corroborated by the BWVC footage.[740]

(b) There was justification for locating D149 in the CSU, particularly in light of his attempt to take Callum Tulley's case and the security report of him being an escape risk.[741]

(c) It was clear from both the UoF report and the video footage that DCM Loughton "*made every effort to persuade D149 to walk to the CSU but eventually he was forced to summon staff for a planned intervention*".[742]

(d) The restraint was difficult because of D149's actions. For example:[743]

> "He then dropped his body weight, which made control even more difficult. When he was taken to the ground a fourth member of staff momentarily took control of his legs but even this was difficult. In my view the correct decision was made to apply handcuffs."

[739] INQ000111_0021-023, para 55, 59-60, 63

[740] INQ000111_0023, para 70

[741] INQ000111_0021, para 56; see also INQ000158_0098

[742] INQ000111_0021, para 57; INQ000111_0026, para 79

[743] INQ000111_0022, para 59

(e) The decision to permit D149 to stand upright once the relocation room had been reached was "*commendable*" given the earlier difficulties and continued abuse from D149.[744]

(f) The planning for the intervention "*followed all procedures as documented in the UOF training manual and PSO 1600, the only omission was recording the briefing*".[745]

(g) Despite the difficulties caused by the abuse meted out by D149, staff "*maintained a professional approach*".[746]

476. He did, however, raise some points of concern in his first report at paragraph 83ff. Taking these in turn:

(a) First, Mr Collier points to the fact that some of the staff were inexperienced – noting that DCOs Tait and Edon were only 5 months in service.[747] Ultimately, once staff are accredited and have passed their training, they are considered suitable for participation in C&R situations. Indeed, all trained and accredited staff are expected to participate in C&R when called upon; doing so avoids the situation where particular staff are perceived to be 'C&R regulars'. That is particularly important given that not all C&R incidents are planned and, accordingly, all staff must be able and willing to use the trained techniques at any time, where necessary. The fact that DCM Loughton stepped in to assist reflects both: (a) the appropriate operational flexibility in the course of the incident; and (b) the particularly difficult restraint that this turned out to be, as the incident developed. While Mr Collier suggests that more experienced staff could have been called, such action potentially would have increased the risk of harm or escalating the situation, given that it would have substantially prolonged the incident: staff would have needed to have been called and would needed to have donned PPE, given that D149 was lashing out.

(b) Secondly, Mr Collier opines that handcuffs were not properly applied during the incident (although the decision to apply them was correct) and that they should have been reapplied.[748] G4S accepts Mr Collier's expertise in this regard, points to the fact

[744] INQ000111_0023, para 65

[745] INQ000111_0026, para 80

[746] INQ000111_0026, para 81

[747] INQ000111_0022, para 62; INQ000111_0026, para 81

[748] INQ000111_0022, para 59-61; INQ000111_0027, para 85

that Mr Collier, himself, recognises that seeking to re-apply the handcuffs in the course of the restraint "*may have been difficult at the time*".[749] When he gave oral evidence to the Inquiry, DCM Loughton was not asked why he did not look to have the handcuffs re-applied; and, in the circumstances, G4S submits it would be unfair for the Inquiry to criticise him for not doing so – particularly in the course of a dynamic situation, where the detained person was lashing out at staff.

(c) Thirdly, G4S accepts the expertise of Mr Collier when it comes to his observations as to the application of restraint techniques generally – such as in relation to the procedure for exiting the cell following relocation; and the execution of the carry technique.[750] It is right, however, to note that:

(i) These errors were in application, rather than in determining which techniques to deploy. In relation to the "*actual movement*", Mr Collier considered that it "*met all of the general principles*"; and "*the decision to carry and use a full relocation were reasonable and proportionate to the threat presented by D149 toward staff*".[751] Any poor display of technique must be considered in the context of a dynamic incident.

(ii) Mr Collier was clear that no unnecessary pain or discomfort was "*deliberate*".[752]

(iii) One particular criticism in this regard pertains to D149 being kept in the prone position for longer than was necessary.[753] In his oral evidence to the Inquiry, David Webb rightly accepted Mr Collier's view in relation to this, but pointed out that use of the prone position had already since been replaced by a 'side relocation'. Following this incident, David Webb explained that there was a change in the use of force manual to a 'side relocation', which he described as akin to the 'recovery position':[754]

> "It used to be the only option was of pretty much a full relocation, which is what you saw on the video there. When I went for my training course, they just adopted what they call a side relocation. Therefore, the detainee went on the floor. For want of a better description, was more in the

[749] INQ000111_0027, para 85

[750] INQ000111_0027, para 87

[751] INQ000111_0028, para 93

[752] INQ000111_0028, para 94

[753] INQ000111_0027, para 86

[754] David Webb 3 March 2022 158/6-159/16

recovery position, so therefore, not laying on his chest and obviously running any risks of other problems, and that obviously changed within the centre reasonably quickly after that – that incident."

(iv) Similarly, Mr Collier points out that when staff applied a Pain Inducing Technique on D149, they should have followed the guidance which was to give a verbal instruction, explaining that a PIT would be applied; repeat that instruction and then apply the PIT for no more than 5 seconds. He observed that in the footage "*none of the above commands are heard*"; but did point out that, in relation to the use of a PIT, itself: "*[it] was reasonable during what was a difficult restraint involving a detainee who constantly attempted to unbalance staff and even tried to kick out at them*".[755] Again, David Webb in evidence rightly accepted that the clear instruction should have been given.[756] In his oral evidence, Mr Collier seems to have given a different view in relation to the appropriateness of applying a PIT.[757] Mr Collier does not explain why, as it appears, his oral evidence is the marked opposite of the considered view he gave in his report, that the use of a PIT was reasonable in the circumstances – nor was he asked. In the circumstances, G4S invites the Inquiry to accept Mr Collier's original written evidence - not least given that the suggestion that it was unnecessary to deploy a PIT was not put or suggested to the relevant officer, David Webb, when he gave oral evidence to the Inquiry.

(v) The same is true of Mr Collier's oral evidence to the Inquiry that "*I think there was definitely more scope there to engage*", when CTI put to him: "*is it also possible that this was not used as a last resort*".[758] Again, with no explanation or exploration, this is the polar opposite of Mr Collier's written evidence, seemingly without the benefit of any new material. In his written report, on 'last resort', he had stated:[759]

"clear evidence of trying to conduct the removal without force by persuading D149 to walk from the room. Once outside he refuses to comply and verbally challenges staff. Force used after all reasonable efforts failed"

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[755] INQ000111_0027, para 89

[756] David Webb 3 March 2022 160/12-25

[757] Jonathan Collier 30 March 2022 39/18-20

[758] Jonathan Collier 30 March 2022 35/9-14

[759] INQ000111_0028, para 92

G4S again invites the Inquiry to adopt Mr Collier's considered, written view. In part that is because it (unlike his oral evidence) took account of the fact that DCM Loughton had earlier "*made every effort*" to persuade D149 to walk to the CSU,[760] and summoning of staff for a planned intervention had already come after earlier abortive efforts. That is also consistent with DCM Loughton's description of his earlier encounter with D149 in his UoF report.[761]

477. Two further points fall to be addressed:

478. In Annex 4 to his first supplementary report (dealing with supplementary questions in relation to D149), Core Participants have suggested that there are "*clear discrepancies in the paperwork*" in relation to D149 having been placed on Rule 40 on 31 May 2017.[762] It is suggested that D149 was placed on Rule 40 at around 17:19, but it was authorised at 22:52, almost 5½ hours later.[763] A small point to note is that the paperwork[764] to which this refers was completed at 21:52, not 22:52. More widely, however, this intimation overlooks an important aspect of the authorisation documentation. This makes clear that the initial authorisation was done on the 'urgency' basis (it was also out of hours at 21:52), and within just over an hour, the Duty Director, Duty Home Office, Duty IMB, medical staff and religious affairs had been informed.[765] More than that, it explains that:[766]

> "Force was used and handcuffs were applied to relocate him to CSU and he was non-compliant all the way down to CSU therefore a full relocation was carried out meaning he went onto Rule 42.
>
> He has now calmed down therefore he has been de-escalated onto Rule 40.
>
> This move has been done for the safety and security of the centre. The Home Office, IMB and Duty Director are all aware."

479. This is Rule 40 paperwork. As a result, it appears that D149 was originally placed on Rule 42 and then, only at 21:52 was he removed from association pursuant to Rule 40 – a 'de-

[760] INQ000111_0021, para 57

[761] CJS005650_0008

[762] INQ000158_0097

[763] INQ000158_0097

[764] CJS001820_0002

[765] CJS001820_0001

[766] CJS001820_0002

escalation' from Rule 42. Accordingly, it is not right that D149 was placed on Rule 40 at 17:19pm. There is no equivalent of Rule 40(6), for example, in relation to Rule 42. In any event, his period of temporary confinement was limited to less than 5 hours.

480. Finally, the next day, David Webb, in conversation with Callum Tulley recorded on the undercover footage made reference to having: "*fucking hurt [inaudible]. Big time. When I put him in a straight hold [inaudible] in the office downstairs heard screaming.*"[767] G4S found an allegation related to this statement to be unsubstantiated.[768] To be clear, however, it accepts that David Webb made those comments to Callum Tulley, but considers to be unsubstantiated the underlying substance – i.e. that he did hurt D149's arm so badly that "*his screams could be heard in other parts of the IRC*". That was a solid conclusion given, as the report sets out:[769]

(a) D149 was extremely vocal from the initial use of force where it is clear staff were using minimum levels of restraint;

(b) Video footage captured the span of the incident and there was no evidence from it of any excessive or inappropriate use of force;

(c) The F213 report records injuries to D149 consistent with the protracted use of force where ratchet handcuffs have been applied due to non-compliance.

481. Mr Collier was asked a leading question by CTI to suggest that these comments point to David Webb having deliberately used pain on D149: "*Would you agree that it appears that it may have even been -- it appears it could have been deliberate, even, by the way that he's talking?*".[770] That was not an open question to elicit Mr Collier's best evidence and thus no weight should be put on the response; especially in light of Mr Collier's written evidence that it was reasonable to use a PIT in the circumstances of this restraint. Moreover, it is Mr Collier's role to provide expert opinion on the appropriateness of the use of force. Whether comments made by a DCO suggest that he acted deliberately or not, does not go to that issue; rather, it is an underlying question of fact to which Mr Collier cannot speak.

482. David Webb, however, can and did give relevant evidence on this point:

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[767] TRN0000088_0020

[768] CJS005979_0009

[769] CJS005979_0009-0010

[770] Jonathan Collier 30 March 2022 47/12-14

(a) He is right to point out that this is an example of Callum Tulley "*fishing for answers*": it was Mr Tulley who started and led the conversation; rather than information proactively volunteered by David Webb.[771]

(b) In any event, the point was that he was simply telling his fellow officers that that technique did hurt – not that he *intended* to cause pain to D149. It was a fact of life that pain was a consequence of that technique – as David Webb, himself, had felt when trained in that scenario:[772]

> "No, I don't intend it to hurt. It is going to hurt. As I've just said to you, it is going to hurt. I've done the same in scenario training, and it hurts. I can say that."

483. Accordingly, G4S submits that the factual evidence before the Inquiry is that David Webb did not intend to cause unnecessary pain or discomfort to D149. Indeed, that is consistent with Mr Collier's original report, in particular his observation that it was reasonable in the circumstances to deploy a PIT. Even if the Inquiry accepts Mr Collier's changed evidence on that issue, the fact that – based on the same material – Mr Collier could originally conclude that it was reasonable to deploy a PIT, militates in favour of accepting that David Webb considered that he was acting appropriately in the circumstances. Where reasonable persons could disagree over whether a PIT should be used in a particular case, the 'inherent plausibility' factor suggests that David Webb would not have consciously and deliberately caused what he, at the time, considered to be unnecessary pain.

Rows 25, 37 and 38: Comments made by Dan Small and Dan Lake on 31 May and 14 June 2017[773]

484. On 31 May 2017, in footage filmed by Callum Tulley undercover,[774] Dan Small said that he would not go to Cleveland as: "*Am not going to black central... Too many blacks, it's eighty percent black*".[775]

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[771] David Webb 3 March 2022 168/3-4

[772] David Webb 3 March 2022 164/17-20

[773] Dan Small only on the latter date.

[774] TRN0000079_0010

[775] TRN0000079_0010

485. Additionally, in reference to fellow employee who had walked past, Callum Tulley pointed out that he was not black, to which Dan Lake responded that "*he is half caste*".[776]

486. Neither of these comments are acceptable. They were not brought to the attention of management at the time, otherwise disciplinary action would have been taken (as it was in the case of John Connolly above).

487. Taking each in turn:

(a) Dan Small accepts that he made the comments above. In his witness statement, his evidence was that: "*I did not consider them to be racist. I now realise them to be racist and am embarrassed and ashamed to be reminded of them… I can only apologise and explain that I was motivated by bravado.*"[777] In his oral evidence, he said that: "*I've got no excuse and I can only apologise*".[778] That latter reaction is the more appropriate one; and G4S would expect it staff to appreciate that those types of remark were racist.[779] It is suggested that Dan Small's explanation in his witness statement is a form of *ex post facto* justification, sought to present himself in a more favourable light. The comments were obviously racist and his 'explanation' rings hollow.

(b) Similarly, Dan Lake accepts that he used the phrase "*half caste*" in relation to a member of staff. He adds, however, that: "*I was not aware that this was an offensive term, and certainly did not mean to cause any offence.*" That explanation is potentially a plausible one, and Dan Lake may not have realised that the appropriate language to use is 'mixed race', rather than the terminology he deployed. This explanation was not, in any event, challenged in oral evidence by CTI and, in those circumstances, G4S submits that it would be unfair for the Inquiry to reject it.

488. Additionally, on 14 June 2017, Dan Small referred to one of the reasons he would not move to London as "*minority white people*"; and said "*can't bear them*" in relation to 'foreigners' (a category in which he bizarrely seemed to place himself as a non-'English' person); he impersonated a Jamaican accent, stating "*fuck off back. Cunt*" in relation to his own

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[776] TRN0000079_0010

[777] BDP000003_0007, para 20

[778] Daniel Small 28 February 2022 136/15-16

[779] As Daniel Lake did, see Daniel Lake 1 March 2022 47/5-13

suggestion that a Jamaican person may wish to kill an English person.[780] In relation to these comments, Dan Small could only say:[781]

> "I accept that some of the comments I made whilst employed at Brook House were of a racist nature and that I displayed a racist attitude at times when talking to other staff. I am extremely embarrassed to be reminded of them as they do not reflect my actual views but were designed to impress or provoke a favourable reaction from colleagues. As the remarks did not reflect my actual views, they did not affect my interaction with detainees".

489. Accordingly, while all such use of language were not appropriate, it should be noted that: (a) they were not in the presence of a detained person (and all, or almost all were not even indirectly about any detained person);[782] (b) Dan Lake explains (with some plausibility) that he did not realise the term 'half-caste' was not an acceptable one to use. No such mitigation or purported justification can be said, in G4S' view, to apply to the comments of Dan Small. It is regrettable that such use of language was not reported at the time either by Dan Lake or, indeed, Callum Tulley.

Rows 26 and 27: Incidents involving Nathan Ring and food refusal

490. These two incidents on consecutive days both concern Nathan Ring allegedly marking down detained persons as having eaten when either he knew that they had not; or without checking. Nathan Ring was, himself, familiar with the Home Office's DSO on care and management of detainees refusing food and fluid,[783] however his conduct suggests that his actions were in breach of those protocols.

491. After Panorama, when these matters were brought to the Company's attention (rather than, as they should have been, by Callum Tulley), Nathan Ring was subject to the Company's disciplinary procedures and was summarily dismissed – in part because of these two incidents.

492. The Company stands by the conclusions drawn by Ben Saunders in relation to these two incidents:

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[780] TRN0000092_50; TRN000068_6-11.

[781] BDP000003_0008-0009, para 24

[782] A point made by Dan Small in oral evidence: Daniel Small 28 February 2022 148/21-149/1

[783] MIL000002_0010, para 24(q)

(a) That on 31 May 2017 Nathan Ring did instruct Callum Tulley to record that a detained person had taken a meal in the knowledge that he had not; and

(b) That on 1 June 2017, Nathan Ring probably did make a comment that there was no need to check whether a number of detained persons had eaten or not, and that they should be ticked off the meal list in any event – in light of the 31 May incident demonstrating Nathan Ring's disregard for the correct procedures on meal checking.[784]

493. The evidence that has emerged before the Inquiry supports these conclusions.

494. In relation to the 31 May 2017 incident, it is clear from the transcript of Callum Tulley's recording that Nathan Ring both: (a) was aware that the detained person had refused to eat; and (b) nevertheless instructed Callum Tulley to cross him off the meal list.[785]

495. Nathan Ring's evidence is that the detained person concerns "*had been eating, he had lots of food in his room, I think, from the shop*".[786] This builds on his written evidence that he was "*aware that he had plenty of food in his room from the shop and had seen him eating his own meals; I knew that there was no welfare issue*".[787] Nathan Ring explains that: "*With the benefit of hindsight, it might have been better for me to mark the register accurately and add accompanying notes to explain that I knew detainees who had refused food at set times were eating but this thought did not occur to me in the moment*".[788] Notably, in oral evidence, rather than suggest that he should have added a gloss or note to the register, Nathan Ring accepted that what he said did not "*sound very good*" ("*don't know, don't care*").[789] Instead, he sought to shift the blame to Callum Tulley – in which he accepted his own comments were "*made… purely out of frustration, but… If the log wasn't completed correctly, that would have been Callum's responsibility*".[790]

496. G4S submits that Nathan Ring's evidence that he 'knew' that the relevant detained person had eaten: (a) is not relevant to the proper completion of the meal register, which is concerned with meals distributed by the IRC; (b) is not an answer in respect of the particular

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[784] HOM001503_0002

[785] TRN0000079_0007; see also Callum Tulley's amendment to the transcript at Callum Tulley 30 November 2021 67/11-15

[786] Nathan Ring 25 February 2022 112/13-14

[787] MIL000002_0020, para 81

[788] MIL000001_0012, para 54

[789] Nathan Ring 25 February 2022 113/13-15

[790] Nathan Ring 25 February 2022 113/22-114/4

meal being checked off (i.e. it is nothing to the point that the detained person may have other food in his room or ate shop food on other occasions); and (c) seems to ring hollow: if Nathan Ring truly thought it acceptable to check the detained person off *because he knew he had other food*, one would expect him to have mentioned so in passing to Callum Tulley, but this is not captured on the transcript. G4S does not, however, go as far as to accept Callum Tulley's suggestion that Nathan Ring "*took pleasure in the suffering of detainees*",[791] which appears based entirely on speculation and isolated incidents without any express comment from Nathan Ring in support of the same. Rather, the more accurate picture is that admitted by Nathan Ring – namely that the comments he made to Callum Tulley were out of frustration (rather than any enjoyment).[792] That interpretation also better accords with the footage/transcript, itself.

497. There is little further consideration of the specific incident on 1 June.[793] Nathan Ring's explanation in his second witness statement is that:[794]

> "It is not clear to me what is happening in this transcript, there appears to be two separate conversations going on at once, but I am unable to see that I directed Callum not to check the top floor for whether detainees had eaten or not. I may be able to assist the inquiry further if I am able to have sight of the footage. The transcript ends with Callum asking if a detainee should be crossed off (as having eaten) and I say that he should, I assume because I knew that the detainee had eaten."

498. Although Nathan Ring is right that two conversations appear to be taking place at once, G4S submits that it is clear enough from the transcript that he had instructed Callum Tulley to cross off the detained persons on the top floor as having eaten without checking: "*Should I just tick him off? Yeh, cross him off*". Moreover, that is consistent with Callum Tulley's contemporaneous account in his notebook, in which he noted that: "*At B wing lunch time I asked Nathan Ring DCM if I should check the rooms on the top floor for the detainees that hadn't eaten. He said he was happy and that they had all eaten – so I marked them off*".[795] Indeed, as Ben Saunders had concluded in relation to Nathan Ring's disciplinary proceedings, consistent with the disregard for the meal register protocols displayed by Nathan Ring the previous day, it can be said on the balance of probabilities, based on the

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[791] Callum Tulley 30 November 2021 70/18

[792] Nathan Ring 25 February 2022 113/13-15

[793] TRN0000088_0002

[794] MIL000001_0014, para 59(a)

[795] BBC000060_0001.

evidence available that he instructed Callum Tulley to mark off those detained persons on the top floor as having eaten without checking.

Row 28: Use of force against D1538 on 3 June 2017

499. The Inquiry has three key guides to this incident – independent of both the complainant and the staff involved: the CCTV footage of the incident;[796] the observations of Mr Collier;[797] and the PSU report into an allegation of assault made by D1538 in relation to the incident.[798]

500. D1538 did not give live evidence to the Inquiry. His account of the incident, per his witness statement,[799] is contained in his PSU complaint and the summary of the interview that he gave to the PSU (as well as his observations on the CCTV footage at paragraph 96).[800] Even putting aside the fact that the Inquiry was unable to test D1538's account through oral examination – and was able to test, for example, DCO Fiddy's – consideration of the CCTV footage alone suffices to undermine D1538's account of the incident. For example, D1538 told the PSU that:

(a) He had not sat at a computer or anywhere;[801]

(b) Both officers had pushed him;[802]

(c) He did not stand up and walk over to the officers;[803]

(d) He never went closer than 1.5 metres away from the officers, but they both came to him.[804]

501. The CCTV footage alone – even putting aside the evidence of the DCO Fiddy and Instone-Brewer show these particular statements not to be correct. They fundamentally undermine D1538's account of the incident.

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[796] Disk 4 UOF136.17 03 June2017

[797] INQ000111_0112-0114, paras 471-488

[798] CJS003348

[799] DL0000231, para 90

[800] HOM002627

[801] CJS003348_0007, para 6.1.6

[802] CJS003348_0007, para 6.1.13

[803] CJS003348_0007, para 6.1.14

[804] CJS003348_0007, para 6.1.15

502. The most contemporaneous accounts are the incident reports and UoF reports of DCOs Fiddy and Instone-Brewer.[805]

503. The Inquiry is likely best assisted by Mr Collier's expert analysis of the incident from the CCTV (and documentation). He explains:

(a) D1538 is obviously unhappy with something and "*seems to be targeting DCO Fiddy*". He goes close to DCO Fiddy, resulting in another detained person ushering him away; before doing so again, causing DCO Fiddy to push him away. "*This is followed by a second push away when D1538 gets close again*". On both occasions the level of force used is a push to the torso area – which is recognised as a personal safety technique.[806]

(b) D1538's body language and actions "*would cause concern for staff and without the benefit of the audio I believe that the two pushes were necessary, if all other attempts at resolving where not effective, and the level of force was proportionate to the threat at that time*".[807]

(c) After the second push, D1538's right arm ends up around the neck of DCO Fiddy, at which point DCO places both of his hands around the neck of D1538 and pushed him backwards. Mr Collier explains in relation to this:[808]

> "This created distance between them and other detainees then usher D1538 away from DCO Fiddy. Although the grabbing by the neck is not a preferred option, I hold a view that DCO Fiddy may have raised his hands in response to the right arm and automatically grabbed the nearest point to push at. In times of confrontation staff can use the whole body as potential targets for defensive techniques. Training does highlight the extreme vulnerable areas, with the neck being among these. As a reactive motion the grab was momentarily and followed by a push away, as opposed to a grab and a strangling' type action. DCO Fiddy had every right under Common Law to protect himself and use reasonable force."

(d) In his oral evidence, when DCO Fiddy was asked whether the footage showed him 'grabbing' D1538 by the neck, his response was consistent with Mr Collier's explanation, namely that: "*It looks like a push. I mean, he's grabbed my arm... I guess 'grabbing' would insinuate wanting somebody to be closer to you, as opposed to being*

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[805] See CJS005649, CJS003708 and CJS003064

[806] INQ000111_0112, para 473

[807] INQ000111_0112, para 473

[808] INQ000111_0113, para 474

pushed away".[809] Additionally, "*it was justified at the time to protect myself and it was, in my opinion, reasonable and no more force than was needed to be*".[810]

504. Mr Collier's overall assessment, which the Inquiry is invited to accept and adopt is that:[811]

> "479. The actions and behaviour described resulted in a necessary UOF. The last push, when the hands were around the neck, are because of the threat and actions demonstrated by D1538 and no more force than was necessary were used.
>
> 480. Even without audio the incident is clear to establish than D1538 is showing signs of anger and venting this towards staff. The conversations are not available but he does move in close to staff in what could be described as a threatening manner.
>
> 481. Once distance had been achieved DCO Fiddy did not make any further attempts at restraining D1538 and allowed him to continue with his activity.
>
> 482. The intervention of other detainees assisted with calming the situation. It has to be considered that they accepted the staff were acting professionally and not being the aggressors in this instance.
>
> …485. Necessary, reasonable, proportionate- The push was a reasonable option under the circumstance and was proportionate to the threat at the time. It was necessary as no other option available.
> 486. No more than was necessary- A low level response to the threat that was appropriate at the time."

505. G4S also invites the Inquiry to consider paragraphs 7.3.2 to 7.3.6 of the PSU report which provides further support for these conclusions, including the final conclusion that:[812]

> "Evidence supports that Mr D1538 was primarily directing his aggression toward DCO Instone-Brewer and that DCO Fiddy placed himself in a position to protect his colleague. That positioning resulted in the invasion of DCO Fiddy's personal space by Mr D1538 and the resultant proportionate use of force."

506. Finally in relation to this incident, G4S notes that counsel for D1538 suggested in his closing statement that afterwards D1538 was then: "*as a punishment, transferred to segregation*

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[809] Ed Fiddy 7 March 2022 171/18-21. It is noted that DCO Fiddy accepted in evidence that he did not include the fact that he had pushed D1538 from the neck in his Use of Force report. He should have done so; however that oversight, of course, does not change what in fact occurred during the incident – as demonstrated by the CCTV footage.

[810] Ed Fiddy 7 March 2022 172/9-11

[811] INQ000111_0114, paras 479-486

[812] CJS003348_0020-0021

without authorisation from the Home Office and without justification in breach of rule 40".[813] That is not correct:

(a) D1538 was not placed on rule 40 as a 'punishment'. Rather, as the DCF1 form explains, it was done: "*after invading an officer's personal space… and tried to grab him around the neck. Duty director consulted and at this present time the use of rule 40 is required to maintain the safety and security of the centre*".[814] D1538 was placed on Rule 40 at 14:30, by which time the Home Office, IMB, medical officer and religious affairs had all been informed.[815]

(b) As such, while the decision to place D1538 was taken by G4S (seemingly in consultation with the duty director) rather than the Home Office, the timings disclose that the Home Office was in fact notified before the detailed person was in fact removed from association. Rule 40 permits G4S to authorise its use in cases of 'urgency'. The PSU considered that there had been time for the Home Office to be consulted before the decision was taken in this case, however the Home Office's own evidence was that; "*As the detainee displayed quite aggressive, abusive and threatening behaviour towards the centre staff, I would not be involved in the decision to place on R40*".[816] There was, at the very least, given the threat to centre staff, a basis on which staff could legitimately have considered this to be a case of 'urgency'. The PSU's conclusion did suggest that this aspect "*may not necessarily have impacted on the decision to appropriately place Mr D1538 into Rule 40 based on his behaviour and actions*"; which is plainly correct.[817] Overall, though, the PSU did not consider this a breach of proper procedure, but rather that, as an example, it suggested that "*consideration be given to clarification of what constitutes 'cases of urgency'*" and that DSO 2/2017 had been release since the incident, which clarified that the Home Office was the prime decision maker in authorising the use of Rule 40.[818] Indeed, the PSU's firm conclusion was that:[819]

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[813] Closing Statements 5 April 2022 73/19-22

[814] CJS001830_0002

[815] CJS001830_0001; see also CJS003348_0023, paras 8.10, 8.14

[816] CJS003348_0025, para 9.1

[817] CJS003348_0025-0026, para 9.2

[818] CJS003348_0026, para 9.3.2

[819] CJS003348_0024, para 8.20

> "In consideration of the application of Rule 40, it is considered that sufficient evidence was found to support that policy and procedure were followed to an acceptable standard and the requirements of Rule 40 were followed in the Removal from Association of Mr D1538"

Row 29: Use of force against D720 on 6 June 2017

507. This incident can be dealt with relatively swiftly: it is one dealt with by Mr Collier in the second part of his first report in light of the fact that, for him, it did not raise any concerns.[820] It was not also investigated by the Inquiry in the course of its oral hearings.

508. Mr Collier's view, is in short that:

    (a) DCO Matchett was entitled to put out his arm to prevent D720 from entering A wing, since D720 was resident on C wing and was not permitted to enter A wing. It was also reasonable and proportionate in the circumstances for DCO Matchett to grab D720's arm to prevent D720 from entering the wing.

    (b) D720 verbally threatened DCO Matchett, telling him to "*get out my fucking way… otherwise you'll have a broken nose*". Those threats by the detained person were unacceptable.

509. The suggestion by D720 that DCO Matchett 'twisted' his arm[821] is not supported by any evidence, although it should be noted that in his complaint form, D720 admits to using threatening language towards staff: "*I responded: 'don't touch me, there's no need to touch me because if I wanted to I would push my way onto the wing*'".[822]

510. The incident was also considered in detail by the PSU.[823] The investigating officer noted[824] that the account given to her by DCO Matchett was consistent with his contemporaneous

[820] INQ000111_0136, paras 593-597.

[821] CJS001526_0002

[822] CJS001526_0002

[823] CJS005989

[824] CJS005989_006, para 6.3.1

account in the UoF report.[825] It was also consistent with the CCTV footage.[826] She ultimately found the complaint to be unsubstantiated, concluding that:[827]

> "Officer Matchett's consistent account was considered credible on balance and his actions were considered reasonable, proportionate and necessary in the circumstances…By D720's own admission he told Officer Matchett he would push his way onto the wing, and became very angry while shouting at Officer Matchett. D720 refused to be interviewed without reasonable explanation. It was considered this cast some doubt on his credibility…It was considered there was no evidence to support D720's allegation that the force on him was excessive."

511. Ultimately, there is no real basis for the Inquiry to take a view other than that of DCO Matchett in his evidence to the Inquiry that: "*… the level of force used as minimal. I released D720's arm as soon as he had stopped advancing onto the wing. I believe that the force I used on D720 was proportionate, reasonable and necessary in the circumstances to protect the safety and security of detainees residing on A wing*".[828]

Row 30: Use of force against D1538 on 6 June 2017

512. This use of force occurred following an altercation between D1538 and D197 in the art room. D1538 gives his account in relation to this aspect of the incident at paragraphs 41-47 of his witness statement.[829] As noted above (in reference to Row 28), the Inquiry did not have the opportunity to explore or test D1538's written evidence during the oral hearings and so it should be treated with some caution generally.

513. Helpfully, there is undercover footage of this incident, which should remove a certain degree of ambiguity from what took place.[830]

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[825] See CJS005580. Note that DCO Matchett's evidence to the Inquiry (BDP000001_0009, para 25) is that: "*Having reviewed the CCTV footage, I can see that it was not in fact me who opened the wing door to D720, as was stated in my use of force report. It was in fact DCO Chris Brown. I moved forward when I saw D720 standing in the doorway trying to get access to the wing. This is the only detail of my use of force report which is not accurate, to the best of my recollection.*" Note that this clarification did not cause Mr Collier to change his opinion of the incident: see INQ000158_0034, para 13.1

[826] CJS005989_008, para 7.1.4

[827] CJS005989_008, para 7.1.4-7.1.5

[828] BDP000001_0010, para 26

[829] DL0000231_0009-0010

[830] KENCOV1031 - V2017060600011

514. The engagement of officers with D1538 commences while D1538 is seeking to re-engage with D197, after other detained persons had pulled them apart from one another. DCM London's report within the Use of Force report pack notes that when he entered the room, he immediately saw D1538 "*with cuts to the left side of neck and in an aggressive stance with his right fist clenched holding a sharpened pencil*".[831] D1538 refers to DCO Bromley's account, which includes reference to D1538 holding a pencil; from which he does not demur.[832]

515. The key point of contention in relation to this incident concerns DCM Farrell's contact (to put it entirely neutrally) with D1538's head. It should be recalled that while D1538 subsequently raised complaints with the PSU in relation to other incidents around this time (see Row 28 and Row 46), he did not do so in relation to this incident. It may be inferred that he did not consider this incident to be consequential at the time.

516. G4S submits that the independent and expert view of Mr Collier should be accepted by the Inquiry. His view is that:

(a) Restraints were applied by "*guiding holds, followed by the head support position as D1538 started to struggle and could have caused injury to the head*".[833]

(b) In relation to the head support position:

(i) "*It is reassuring that staff only applied a guiding hold when the head support was adopted. It demonstrates using the appropriate force even when there is resistance by the detainee*".[834]

(ii) It was applied:[835]

> "momentarily before allowing D1538 to come upright before re-applying the head support position for a longer period until the restraints are released. The technique applied is consistent with training and is necessary due to the continued struggle and potential risk of staff being thrown off balance in an area full of furniture."

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[831] CJS005615_0004

[832] DL0000231_0011, para 53

[833] INQ000111_0099-0100, para 406

[834] INQ000111_0100, para 407

[835] INQ000111_0100, para 409

(iii) It was applied "*for the safety of D1538*".[836]

(iv) It was proportionate in that: "*Once the head support was no longer required it was removed, and then re-applied when the situation escalated*".[837]

(c) Overall, "*it appears that force was necessary and when applied only with the proportionate amount, and for no longer than necessary*".[838]

517. D1538 contends that: "*it is not true that the officer [DCM Farrell] grabbed my head to stop me hurting myself, or to stop me hitting a metal cupboard*".[839] G4S submits that there is no substantive reason why the Inquiry should digress from the analysis of Mr Collier in particular in circumstances, where D1538's supposition could not be explored with him in oral evidence. Further, Mr Collier stood by his conclusion that the force used was proportionate in his first supplementary report, when faced by what is essentially a case put to him by D1538's representatives that it was not.[840] That included specifically in relation to the use of the head support. He explained:[841]

> "Controlling the head reduces the movement of a detainee and allows controlling holds to be secured. By gaining control the incident can de-escalate more effectively but, on this occasion, D1538 continued to resist staff. I disagree with the comment that this was an unnecessary UOF as D1538 did not calm down and staff used the approved techniques for restraining a detainee".

518. Indeed, it should be recalled that Mr Collier's view was not only that the action taken by staff was justifiable, but further that it was "*reassuring*" that only guiding holds were used in the face of a resistant detained person: insinuating that other officers may have – perhaps with some justification – deployed stronger restraints.

519. Furthermore, the head support was explored in oral evidence with the relevant officer, DCM Farrell. He explained in evidence the importance of being supportive with the head, and trying to "*not dip the head below the heart*".[842] The Inquiry will note from the footage itself, that the head does not in fact dip below the heart at any point, in line with this guidance.

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[836] INQ000111_0100, para 410

[837] INQ000111_0101, para 418

[838] INQ000111_0100, para 408

[839] DL0000231_0011, para 54

[840] See INQ000158_0094-0095

[841] INQ000158_0095

[842] Shane Farrell 8 March 2022 94/22-25

When CTI explored with him that he was he was doing was (in CTI's words) "*quite rapidly pulling his head downwards*", DCM Farrell explained quite straightforwardly that: "*It's how you take control of the head. That's the way I've been trained and I've never been pulled up on my technique*".[843] Indeed, that response is unsurprising. If it had been otherwise, and his technique was unorthodox or inappropriate in any way, Mr Collier would have made that observation. For the same reason, DCO Bromley in his oral evidence had no qualms about describing DCM Farrell's technique as "*textbook*".[844]

520. In terms of the specific risks that DCM Farrell sought to obviate by providing head support, in oral evidence he broke this down in alignment with the initial and subsequent head supports he provided. He accepted that the first time he supported D1538's head he was not near the cabinet and DCM Farrell had taken the head because of the risk which was to staff and to D1538: "*He could have hit his head on the staff, on their shoulders or something, could have caused real issues. He was actually resistant, so I took control of the head*".[845] He accepted that his initial report had referred to the cabinet, but that was his genuine belief (even if mistaken at the time). Taking a realistic approach, that is understandable. The initial head support was very brief and quickly overtaken by the subsequent support. In relation to that second support: "*there was definite risk as he was right up against the cabinets*".[846] Again, that is borne out by the undercover footage.

521. As a result, this incident should truly be seen as it has been by Mr Collier: a commendable display by staff of an appropriate response to a fast-developing situation, in which they in fact displayed constraint. There can be no real qualms about DCM Farrell's use of the head support: Mr Collier certainly saw no room for criticism; and DCO Bromley routinely described it as "*textbook*".

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[843] Shane Farrell 8 March 2022 97/2-4

[844] Ryan Bromley 7 March 2022 123/21-24; 126/10; 129/9; and notwithstanding that it was put to him that he had subsequently told Callum Tulley that DCM Farrell "*almost took [D1538's] head off*". DCO Bromley stood by the fact that he had no concerns about DCM Farrell's actions: see SER000434_0031, para 124. Such a comment does not change the underlying nature of the incident, which is clear on the undercover footage.

[845] Shane Farrell 8 March 2022 97/19-25

[846] Shane Farrell 8 March 2022 98/2-4

Row 31: Allegation that Derek Murphy told Callum Tulley to cover up a self-harm incident

522. This is an incident in respect of which there is scant evidence and G4S submits that there is insufficient evidence for the Inquiry to make any findings in respect of it:

(a) The SoI refers to only a limited number of documents – essentially only footage filmed by Callum Tulley and Callum Tulley's own written statement from camera. Of those, the transcripts of the undercover filming referred to do not actually provide any support or corroboration for the allegation that Derek Murphy instructed staff to cover up any act of self-harm.[847]

(b) As such, the only source of underlying material is Callum Tulley's own statement to camera, to the effect that: "*Later Derek took the two officers from E wing Ceri and Ryan and said that D149 had been self harming but not to put anything down about it, so that they could avoid having to do constant observations on the wing*".[848]

(c) However, Mr Tulley does not give evidence about this incident in his written witness statements; he was not asked about it, nor did he address it orally before the Inquiry; and – perhaps most importantly – Derek Murphy was not asked about it when he gave his oral evidence to the Inquiry. Were the Inquiry to make findings that he acted in any way improperly, fairness demands that he should have been given a proper opportunity to understand what had been alleged and to respond to it.

523. In sum, therefore, there is no witness evidence in relation to this allegation; the underlying undercover footage referred to in the SoI does not support it; and, as such, the Inquiry is simply not in a position to make any findings in relation to it (on *any* standard of proof – even a 'suspicion').

Rows 32, 33 and 42: Allegations by D2953 that Derek Murphy hit him on 10, 11 and 16 June 2017

524. These three incidents comprise a set of allegations made by D2953 that Derek Murphy hit him on 3 separate occasions: on 10, 11 and 16 June 2017.

525. The primary source of evidence available to the Inquiry is that gathered by the PSU as part of its consideration of the complaint made by D2953, which was first raised by solicitors'

[847] TRN0000090_5 -9;15 -20

[848] CPS000025_0031 (9.6.17)

letter of 28 September 2017.[849] That was some three months after the incidents allegedly occurred, notwithstanding that D2953 did make other complaints about other matters in the interim.[850]

526. The PSU investigation is the primary evidence source because:

(a) D2953 has not provided a witness statement to the Inquiry; nor did he give oral evidence to it. Instead, his account was 'read in' to the Inquiry by means of the Inquiry's own summary of interviews given by D2953 to G4S and the PSU in 2017.[851] That is not formally D2953's 'witness evidence': it is not accompanied by a signed statement of truth; nor was D2953's account open to questioning by CTI or any Core Participants (through the Rule 10 process).

(b) Derek Murphy's clear evidence – both in his statement[852] and orally,[853] was that he had no recollection of the alleged incidents which formed the subject of D2953's complaint. He explained that this may have been because in: "*the last five or six years, I've been using a lot of alcohol and prescribed drugs to get over my PTSD and my anxiety over a lot of stuff, including this.*"[854] However, he did make absolutely clear that he "*did not and would not punch a detainee*".[855] That evidence was not challenged under questioning by CTI and it would be unfair for the Inquiry to reject it, without it having been challenged under examination, when Derek Murphy could have provided a response to any challenge.

(c) There is no footage of the alleged incident[s].

527. The PSU considered these allegations, although given that they were not raised until September 2017, by which point a number of potential witnesses had left G4S, it was not possible for the PSU to gather all relevant evidence. Indeed, the PSU decided not to pursue 3 potentially relevant witnesses for this reason.[856] The PSU's conclusions were thus based

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[849] CJS001506_0022, para 1.3

[850] E.g. CJS001616

[851] D2953 (read-in) 9 December 2021 147/5-8

[852] INQ000121_0010, paras 34-39

[853] Derek Murphy 2 March 2022 111/16-23

[854] Derek Murphy 2 March 2022 112/1-3

[855] INQ000121_0010, paras 34-35

[856] CJS001506_0026, para 5.8

on the limited information available to it; rather than all the evidence it would likely wished to have gathered.

528. It is also important to be clear regarding what *exactly* the PSU concluded. D2953 alleged that Derek Murphy hit him on three occasions. The PSU at no point made an express finding that Derek Murphy had hit D2953. Rather, its language is more circumspect, noting that: "*on a balance of probabilities that it is highly likely, that there was some sort of incident involving D2953 and Officer Murphy*" (emphasis added).[857] Even in the final conclusion at paragraphs 7.2.3-7.2.4 the PSU officer finds: "*leads to the conclusion that something did happen to D2953 as he states… Therefore on the balance of probabilities the conclusion reached by this investigation is that there is substance to D2953's allegations[;] consequently the allegation is substantiated*" (emphases added). As such, there was no express finding that Derek Murphy hit D2953 three times (or that any use of force by Derek Murphy was inappropriate). Rather, the findings only go as far as to suggest that there is 'something' to what D2953 has alleged. It should also be recalled that by the time of the PSU's findings, Derek Murphy had already had his DCO certification suspended and revoked by the Home Office and had been dismissed by G4S – for matters not related to D2953's allegations.[858]

529. The Inquiry is accordingly not in a position – given the paucity of evidence available – to go further than the PSU's conclusions that 'something' probably occurred between Derek Murphy and D2953 on some or all of 10, 11 and 16 June 2017. It cannot, however, it is submitted, conclude – certainly not on any meaningful standard – that Derek Murphy actually hit D2953, let alone make any findings as to the nature of the incidents. Indeed, even if (which is not accepted), the Inquiry could conclude that Derek Murphy 'hit' D2953 on some or all of those occasions, that would be of little meaning without the ability – which the Inquiry plainly does not have – to provide any meaningful context to the incident: did he 'hit' D2953 in self-defence? Was it an act of aggression? Was it in fact an unplanned use of force? If so, was it properly executed? The Inquiry simply does not have the evidential material available to answer any of these questions. Indeed, the *possibility* that any action taken by Derek Murphy was to protect the Centre from damage arises from D2953's own account, in which he accepts that on 10 June he was not just hitting and shouting at the door,

[857] CJS001506_0033, para 7.1.7

[858] See HOM005832, CJS0073011, CJS0073058, CJS0073152, HOM005821.

but also "*kicking at it*".[859] That is also consistent with contemporaneous evidence (of 9 June 2017) that D2953 had "*erratic behaviour*", including spitting at staff, breaking his cutlery set and throwing his kettle at the door.[860]

530. Moreover, the documentary materials that are available raise serious questions about the credibility of D2953's own account. Of course, though, given that D2953 did not give evidence directly to the Inquiry, these could not be put to him, nor his account tested. For these reasons, the Inquiry is invited to treat D2953's account with a degree of scepticism:

(a) There is a consistent thread from various sources that D2953 was financially motivated, which may have driven him to raise his complaint about this issue, which first materialised in pre-action correspondence from his solicitors. For example, Derek Murphy told the PSU investigator that: "*D2953 used to walk around the wing saying it was his human rights and that he wanted compensation*";[861] similarly, D2953 told the PSU that he hoped to receive some compensation;[862] and also said to G4S' investigator: "*I have health problems and need money, are you going to give me some for this?*".[863]

(b) As noted above, D2953 raised this complaint with G4S/the Home Office first by means of letter from his solicitors some three months after the incidents had allegedly occurred. He did so, notwithstanding that he had raised complaints earlier in relation to other issues – and so plainly was aware that he could do so, and knew how. This delay is unexplained.

(c) D2953's account is that he did not seek medical assistance, even though he had been bruised by the incident.[864] G4S suggests that if D2953 had been hit in the manner he suggested, causing bruising, he would have raised this with medical staff, especially as he attended healthcare for other reasons on a number of occasions on 11, 12, 15 and 16 June.[865]

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[859] CJS0073658_0001

[860] HOM005193_0003

[861] HOM004878_0001

[862] HOM004880_0008

[863] CJS0073658_0002

[864] CJS001506_0027, para 6.1.4

[865] CJS001506_0032, para 6.9.5

(d) It appears that D2953 has changed his account without explanation. The PSU report refers to two examples where D2953 referred to having been bitten rather than hit. It goes on to suggest that both individuals to whom those complaints were made "*may have misunderstood D2953*".[866] It is respectfully suggested that such an explanation is less plausible where it applies to two separate instances; and the more likely position is simply that between 20-29 June D2953 claimed that he had been bitten; and then he changed his story.

(e) There is an inherent implausibility to D2953's account – that on each of the 3 occasions, different, other officers were nearby or witnessed Derek Murphy's violence towards him – but seemingly none of these individuals (who D2953 did not name) either stepped in to intercede or reported Derek Murphy for the conduct. If there had been one bystander, it is possible that such a person may not have seen the incident[s] or may not have reported them; but it simply is not plausible that multiple officers all turned a blind eye to a colleague allegedly punching a detained person.[867]

(f) The PSU report relied on the Panorama programme for circumstantial evidence.[868] However, there was no footage on Panorama of Derek Murphy actually using physical violence towards (e.g. punching) any detained person.

531. For these reasons, G4S submits that the Inquiry should not find that Derek Murphy punched or hit D2953 on 10, 11 or 16 June 2017. It is respectfully suggested that, at its very highest, the evidence would only permit the Inquiry to 'suspect' that – as the PSU found – 'something' took place between Derek Murphy and D2953. However, there is insufficient evidence available to make meaningful or reliable findings, even on a 'suspicion' basis beyond that; and certainly not any findings concerning Article 3.

Row 34: Response to D368 reacting to substance misuse on 11 June 2017

532. This is a further incident in respect of which the Inquiry has before it scant evidence and which was not explored in oral hearings (for example with either Nathan Ring or Steve

[866] CJS001506_0033, para 7.1.5

[867] See CJS0073658_0001 ("*young guard*" as witness); CJS0073658_0002 (man with tattoo and earring as well as unnamed manager both as witnesses); see also HOM04880_0003, 0005-0006.

[868] CJS001506_0034, para 7.1.12

Loughton). In light of the limited relevant evidence available, G4S submits that the Inquiry is not in a position to – and thus should not – make any findings in relation to it.

533. The chief source of evidence in relation to this incident is Callum Tulley: his notes and his video diaries, but not explored in either his formal witness statements to the Inquiry, nor in his oral evidence.

534. In his written notes,[869] Callum Tulley merely states: "*there was a medical response to b-wing top floor detainee slumped snot running out of his nose, spice, man in his 40 [sic], D368, surname uncertain. Managers and nurses thought hilarious — didn't say anything awful but not professional*". Accordingly, the allegation goes no further than the conduct having been unprofessional (but nothing 'awful' said); with no identification of exactly what was said or done and no identification of the officers allegedly involved.

535. Some further material is gleaned from Callum Tulley's video diaries:[870]

> "And immediately the jokes start being cracked, you know. In just the most patronising way, you know. Saying, "Have you had a little smoke? Feeling better now". Just -- this is a man who's probably in his fifties, at least in his forties. He's got kids. He's got family. And he's just being mocked by the managers and the nurses in the most condescending way."

536. One should not that Callum Tulley, himself, did refer to D368 having snot drooling out of his nose as "*disgusting*".[871]

537. Again, there is no identification of the staff involved. Nathan Ring's evidence is accordingly understandable – to the effect that: he could see no reference to being present at the incident and could not recall it; and was confident that if he had been present, Callum Tulley would not have omitted to mention this.[872]

538. Callum Tulley's video diary entry does refer to a staff member saying: "*Have you had a little smoke? Feeling better now*", which – as can be seen above – Callum Tulley interpreted as mocking and patronising. DCM Steve Loughton has admitted stating to D368 on 11 June 2017: "*feeling good are you, had a little smoke have you*".[873] However, he explains having done so as based on his good rapport with D368 (having known him for 9 years) and as an

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[869] CPS000025_32

[870] TRN0000068_0018

[871] TRN0000082_0007

[872] MIL000001_0017, para 64

[873] CJS005937_0008

attempt to get D368 to respond to and acknowledge him, rather than being rude or disrespectful.[874] He stood by this in his written evidence to this Inquiry – explaining that what he said to D368 on 11 June were based on his "*good rapport*" and were "*made in a friendly and familiar tone*".[875] That evidence was not challenged when Steve Loughton gave oral evidence to the Inquiry; and, in the circumstances, it would be unfair for the Inquiry to reject it without any contrary facts or case being put to him.

539. For these reasons, and because of the highly limited evidence available to the Inquiry in relation to this Incident, G4S submits that the Inquiry should not make any factual findings in relation to it.

Rows 35 and 36: Comments made in relation to D1275 following spice attack on 14 June 2017, and further comments made the same day by Derek Murphy

540. This incident concerns comments made to D1275 by Nathan Ring in the course of having a spice attack on 14 June 2017.

541. G4S' position – now as when it learnt of these comments – is that what was said by Nathan Ring and Derek Murphy was inappropriate and unacceptable and not how G4S expected its staff to treat those in its care.

542. In relation to Nathan Ring, the transcript[876] records him having called D1275 a "*div*", a "*scrotum*", encouraging him to sing in the course of his spice attack and commenting "*bucket of cold water will sort his heart rate, that would do him the world of good*". Nathan Ring does not deny having made these comments. All he says by way of 'defence' is that:

    (a) His comments did not prevent D1275 receiving appropriate care (as is clear from the footage and transcript).[877] G4S agrees with that statement in the formal sense – that is to say that Nathan Ring's comments did not prevent, for example, healthcare attending the scene and providing medical care, as required. However, 'care' for detained persons goes wider than just medical provision; it includes how officers and staff treat detained persons. These comments made by Nathan Ring in the course of D1275's

[874] CJS005937_0008

[875] SER000447_0023, para 107

[876] TRN0000092

[877] MIL000001_0018, para 66.

spice attack reflect him falling below the standards of care with which G4S expects its staff to treat detained persons.

(b) The comment in relation to cold water was "*clearly not made in anything other than jest*".[878] G4S accepts that is likely to be true: but it is no answer. Although the misconduct would have been more serious had Nathan Ring intended to throw cold water over D1275, there is no real suggestion that he did. Rather, part of the very concern about these comments was the fact that Nathan Ring considered it appropriate to 'jest' about a detained person's condition in front of him, in the course of a serious medical episode.

(c) His comments were "*largely born out of an enormous sense of frustration*", since he had spent time with D1275 in the preceding days and tried to reason with him about staying away from spice.[879] Again, that may well be the case; however, even if true, it is not an excuse. G4S expects staff not to fall below its standard of professionalism whether frustrated or otherwise.

(d) In oral evidence, Nathan Ring tried to suggest that his interactions with D1275, in light of the rapport between them was: "*along the lines of going out with friends and one of them has a bit too much to drink*".[880] As CTI pointed out, though, this was someone in Nathan Ring's care, not a 'mate'.

(e) The comments were made in D1275's physical presence, but there was no way that D1275, in the state that he was in, understood what Nathan Ring was saying. That did not make the comments acceptable, but meant that they were made to colleagues, not to the detained person.[881]

543. As explained above, once G4S was made aware of these comments, it acted swiftly in light of their serious unprofessionalism. He was suspended from duty on a precautionary basis on 25 August 2017;[882] and on 14 September 2017 he was summarily dismissed for gross misconduct – notwithstanding that he had already tendered his resignation. Ben Saunders concluded in relation to the comments of 14 June 2017 thus:

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[878] MIL000001_0018, para 67.

[879] MIL000001_0018, para 68; MIL000002_0019, para 76.

[880] Nathan Ring 25 February 2022 121/3-7

[881] Nathan Ring 25 February 2022 121/11-21

[882] HOM001841

> "The footage viewed in the disciplinary meeting indicates that you did make the comments stated in the allegation. You slated that you made these comments either out of frustration or anger and are aware that they are not appropriate. You said you made the comment around the cold water to Healthcare and that this was not in a mocking way. You also said the comments about singing were when he was coming around from his intoxication and were in jest.
>
> I find the comments inappropriate, particularly as they are demeaning to the detainee and unprofessional."[883]

544. Similar observations can be made in relation to the comments made by Derek Murphy towards D1275: "*look at the state of that*", "*imagine bringing that home to mother*" and "*if he dies, he dies*".[884] G4S considers these comments to be unacceptable and unprofessional.

545. Derek Murphy's response was, in some respects, not dissimilar from that of Nathan Ring, suggesting that he said this "*out of frustration*".[885] He did recognise, though, that "*it's not very nice, and I apologise to the inquiry for it… it was very unprofessional*".[886] Derek Murphy also added that some of the footage had been "*cleverly edited for effect*";[887] G4S does not accept this in relation to his comments and – in any event, it is besides the point and does not detract from their inappropriateness. It is right to note, though, that it does appear Derek Murphy used the phrase "*if he dies, he dies*" as a reference to one of the Rocky films (rather than, for example, showing genuine disregard for whether the detained person survived).[888]

546. G4S' position is the same in relation to other comments made the same day by Derek Murphy.[889] In the course of his investigation by G4S, the allegation concerning these comments ("*tell him if he keeps going I'm going to smash the fucking shit out of him*"), Derek Murphy was not even contested by him.[890] His only mitigation offered was that while he accepted the comments were not professional, he had a good rapport with the detained person and was subsequently asked to accompany him to a psychiatric hospital, reassuring him that

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[883] HOM001503

[884] TRN0000092; TRN0000015_0021

[885] Derek Murphy 2 March 2022 77/17

[886] Derek Murphy 2 March 2022 77/17-24

[887] Derek Murphy 2 March 2022 80/13

[888] INQ000121_0006, para 18(a)(i); Derek Murphy 2 March 2022 83/1

[889] TRN0000092_24-28

[890] HOM005830_0005

everything would be okay. He added in oral evidence that he also received an employee of the month award for his other work with this detained man.[891] It was because of that rapport that, he said, the detained person would know he did not mean it.[892] Consideration of the underlying clip does suggest that there was no real menace to these words, but that does not render them acceptable in any way. Derek Murphy was also clear that the mention of "*be[ing] in trouble*" with him[893] was a reference to taking the detained person's tobacco; and "*absolutely not*" anything physical.[894]

547. All these comments were, in G4S' view, unacceptable and accordingly Derek Murphy was subject to disciplinary proceedings in relation to them, leading to a sanction of a final written warning on 12 October 2017.[895] Consideration of the disciplinary outcome document suggests that it is fair to say that Derek Murphy received a final written warning (rather than be dismissed) because of some mitigating features:[896]

    (a) The comment concerning D1275 was made in private to a colleague;

    (b) Derek Murphy had no previous disciplinary record;

    (c) He showed openness and honesty at the disciplinary hearing;

    (d) There were some mitigating operational pressures (e.g. long shifts and staff rotation);

    (e) He "*showed remorse for your actions and recognised the need to empathise with detainees in order to try and understand their behaviour*".

548. In any event, he was dismissed a month later on 15 November 2017 when his DCO accreditation was permanently revoked following Panorama.[897]

549. As set out above, G4S' clear view in relation to the comments made by both Derek Murphy and Nathan Ring is that they fall far below the standard expected of G4S officers: they do not reflect the type of attitude that G4S expects its staff to show towards those in their care.

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[891] Derek Murphy 2 March 2022 54/21-24

[892] Derek Murphy 2 March 2022 55/22-24

[893] TRN0000092_0026

[894] Derek Murphy 2 March 2022 57/17-23

[895] See HOM005830 and CJS0073011

[896] CJS0073011

[897] CJS0073152

Such comments may have been borne out of frustration, but that does not render them acceptable.

550. Nevertheless, G4S does not accept that these incidents cross the line in terms of a violation of Article 3 ECHR. In that regard, the officers' motives (venting frustration rather than to demean) are relevant; as is the fact that this is a essentially a short, one-off incident in respect of D1275 and in the case of both officers, the comments were made either in D1275's absence, or in the clear expectation that D1275 was not in a position to hear or understand them. There is no room for 'sounding off', 'locker room chat' or the like; and these comments were not acceptable in light of G4S' high standards for its staff. However, the Article 3 bar is also a high one – and unprofessional comments of this nature, in this context, do not cross it.

Row 39: Use of force against D313 on 15 June 2017 by Sean Sayers

551. This incident is not an example of force being used in the form of control and restraint, but rather Sean Sayers (on his account) deploying an unorthodox technique for personal protection against D313. The Inquiry has evidence in writing from both D313 and Sean Sayers (amongst others); however of those two protagonists, only Sean Sayers gave oral evidence to enable his account to be explored and tested under examination.

552. There are a few preliminary points which undermine the credibility of D313's account of the incident:

(a) The incident occurred shortly after D313 suffered a spice attack; he was observed by a nurse as 17:35 after the medical emergency, still presenting as "*confused*".[898] No doubt this had some – possibly serious – impact on D313's cognitive functions and memory that afternoon/evening.

(b) Those medical records which evidence D313 having been seen by nurses on 15 June 2017 at 17:35, 17:42, 18:50, 19:48 and 21:57 do not contain any reference to D313 having received, as he claims "*a full punch to the face*" causing a "*red and bruised*" cheek;[899] nor any evidence of self-harm which D313 reports to have carried out

[898] CJS006629_0005

[899] DL0000233_0015, paras 67, 71

afterwards.[900] On the contrary, he was reported at 18:50 to be "*jovial in mood*".[901] The incident, however, appears to have taken place prior to 18:30.[902]

(c) D313 did not, as one may have expected him to, raise any complaint in respect of the alleged punch he is said to have received from Sean Sayers.

(d) D313 identifies no possible motive for an attack against him specifically. Rather, he suggests that Sean Sayers must have been "*angry at something*" and so punched him as a result.[903]

553. As a result, the core evidential basis for the allegation are comments picked up by Callum Tulley in his undercover recording. However, those transcripts are consistent with D313 having provoked the situation. D313 speaks with Callum Tulley and refers to Sean Sayers as a "*fat cunt*".[904] Dan Lake then describes what had happened, namely that D313 "*called Sean a fat cunt, and Sean went "do something about it then" and then [D313] come [sic] over like he was going to hit Sean, Sean grabbed him and threw him in his room…* ".[905] The consistent language ('fat cunt') – i.e. that D313 clearly uses those words in relation to Sean Sayers gives credence to the account. Further, Dan Lake added that: "*to be fair on Sean [inaudible], it looked like he was going to hit Sean, like the way he approached Sean with his hands back like that*".[906] That narrative is also consistent with what Sean Sayers, himself, separately said on the undercover footage: "*He just went for me*".[907]

554. These accounts give a clear and consistent picture of the incident being provoked initially by D313 insulting Sean Sayers and then approaching him (Sean Sayers) with an apparent intention to attack him.

555. The narrative is then best picked up from the G4S investigation report into the incident, which collates the various strands of evidence.[908] From the investigation it appears that:

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[900] DL0000233_0015, para 70

[901] CJS006629_0006

[902] See TRN0000093_0026 (line 949)

[903] DL0000233_0015, para 67

[904] TRN0000093_0026 (line 948)

[905] TRN0000093_0027

[906] TRN0000093_0028

[907] TRN0000093_0031

[908] CJS005937

(a) When D313 rushed towards him, Sean Sayers got hold of D313 in a 'bear hug', lifted him on the floor, carried him back to his room and locked the door. This type of restraint is not taught to G4S staff or contained within the C&R manual.[909]

(b) Sean Sayers claimed to have been unaware that the incident had been seen by DCO Gary Croucher and DCO Dan Lake.[910]

(c) Sean Sayers denied assaulting D313.[911]

556. Ultimately, the G4S investigators concluded that there was insufficient evidence to support the allegations of assault by Sean Sayers of D313, but: "*there is sufficient evidence to demonstrate that DCO Sayers employed an unapproved use of force upon D313 and lied when he stated that he was alone during this incident*".[912] Sean Sayers' evidence to this Inquiry is that he was genuinely unaware that the other officers had followed behind him; but he learned this subsequently when viewing the CCTV footage.[913]

557. As a result of the investigatory and disciplinary processes, Sean Sayers was issued with a final writing warning on the grounds that he had carried out an unapproved use of force technique against D313 which he had failed to report.[914]

558. In giving his evidence to the Inquiry, Dan Lake did not recall witnessing Sean Sayers hitting D313.[915] He was clear about that under questioning from CTI.[916] He did not even recall the incident when questioned in 2017 as part of the G4S investigation.[917]

559. Sean Sayers' oral evidence to the Inquiry included one aspect that was not contained in his interviews with the G4S investigators: that Sean Sayers had "*tripped onto the bed... when I got up, I've put my hand down to get up off of a kneeling position and his face was there*".[918] It may appear odd that such a detail did not emerge in the investigatory interview, but it is

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[909] CJS005937_0009

[910] CJS005937_0010

[911] CJS005937_0009

[912] CJS005937_0011

[913] BDP00004_0017-0018, paras 63, 66; Sean Sayers 10 March 2022 156/9-10

[914] CJS0073341_0001

[915] BDP000002_0019, para 57

[916] Dan Lake 1 March 2022 59/12-14

[917] CJS005937_0006

[918] Sean Sayers 10 March 2022 152/20-25

to be recalled that the questioning of Sean Sayers by the Inquiry was done with the benefit of the undercover footage transcripts, while the investigatory interview was not. This response arose in relation to a question arising from comments picked up in the footage.

560. Ultimately, G4S submits that the Inquiry is in a broadly similar position to its own investigators. There is relatively clear evidence that Sean Sayers used an unorthodox – to say the least – technique of moving D313 to his room. It is fair to say that the technique was not an approved one, although it should be noted that Sean Sayers does say that his approach to "*wrap him up like that*" was reasonable in response to D313 being "*aggressive and motioning*" – an act of personal protection.[919] Furthermore, it is also right that Sean Sayers can be criticised for a failure to complete any paperwork in relation to the incident – a UoF report and/or a SIR, which would have been appropriate; as well as a failure to alert a medical practitioner to assess D313 afterwards.

561. Beyond that, however, all that can really be said is that the evidence is conflicting and unsatisfactory – especially on the key question of whether Sean Sayers 'accidentally' slapped or leant on D313. In that regard, there is no clear, direct evidence that this took place. The closest would be D313's own account, which is inconsistent with that of all other witnesses and, for the reasons explained above, has serious credibility questions – even putting aside the fact that there was no opportunity for CTI or the Chair to test this evidence. No real reliance can equally be placed on what Dan Lake said to Callum Tulley on camera – given Dan Lake's clear evidence that he did not recall the incident – both to this Inquiry and to the G4S investigators in 2017. More than that, when questioned by CTI, Dan Lake's evidence was that if he had seen Sean Sayers 'backhand' someone he probably would have remembered it.[920] The implication of that evidence, combined with his further evidence that he did <u>not</u> recall seeing Sean Sayers 'backhand' anyone, was that Sean Sayers did not do so. As such, the Inquiry can validly criticise Sean Sayers' personal protective technique as he applied it to D313, as well as his failure to record the incident properly (or at all); but is simply not in a position, on the evidence, to make any finding that he assaulted D313 in any way.

[919] Sean Sayers 10 March 2022 160/20-161/5

[920] Dan Lake 1 March 2022 60/20-23

Row 40: Use of force against D1853 on 15 June 2017

562. This incident concerns the use of force against D1853 to facilitate his removal on 15 June 2017. It is an incident in respect of which the Inquiry has heard little evidence (e.g. no evidence during the oral hearings),[921] and there is not a substantial degree of documentary material. The core materials are the UoF report forms;[922] and the video footage available.[923] It is on the basis of that footage made available that this is one of the incidents in respect of which Mr Collier changed certain aspects of his original views.

563. Mr Collier summarises the key aspects of the incident in his second supplementary report. He observes that:

(a) The incident starts with staff entering room A105 occupied by two detainees, one being D1853. DCM Lyden explains that D1853 is to be moved and his clothing is checked before being allowed to dress himself. He then walks out of the room and down the landing.[924] G4S adds that the footage shows staff acting in a calm and respectful manner towards D1853: not rushing him and explaining to him what would be taking place. It takes almost four minutes (as D1853 is not rushed) for him to get dressed and leave the room. No force is used during this aspect of the incident.

(b) "*Once the staff reach the end of the landing, D1853 moves away and is effectively cornered. He then refuses to move (04:04 on the footage) and after a short period, (04:20 on the footage) force is initiated after an Instruction by DCM Lyden.*"[925]

564. The key question is whether the application of this force was appropriate in the circumstances. DCM Lyden describes the decision in his UoF report thus:[926]

> "At this point he said he would not go with out his property , I said again that once off the wing he would get his property, I wanted to get him off the unit as we were in an open space and to eliminate the risk of the detainee running around and the potential of getting on the netting, he then said that we would have to fight him, he then started throwing his arms about and getting irate as this happened his arm came towards me and I

[921] Ryan Harkness' witness evidence is that: "*It is my honest belief that the force used was proportionate, reasonable and necessary*": SER000440_0032, para 106.

[922] CJS005648

[923] UOF 153.17 BWC / CAM

[924] INQ000177_0010, para 37

[925] INQ000177_0010, para 39

[926] CJS005648_0019

> pushed his right arm down towards the floor before one of the other officers took control of the arm."

565. On viewing the footage, it is right that D1853 was irate at this point and "*throwing his arms about*", as DCM Lyden reports. Mr Collier's view is that the risk of D1853 accessing the netting with six staff in attendance was low.[927] That must be right. It is Mr Collier's view that the 16 seconds between when D1853 stopped moving and the application of force was insufficient and more time should have been given to explaining the situation and reassuring him that his possessions would follow him to the discharge area.[928] His view, therefore, is that – strictly speaking – force was not necessarily the last resort. There is some force in what Mr Collier has to say about that. G4S adds, however, that:

(a) When the footage is considered in its entirety, including the preceding 4 minutes, staff had already taken substantial steps to explain repeatedly that D1853's belongings would be packed and brought down for him (see, e.g., the reference to his roommate knowing which items belonged to him, etc.).

(b) Although the risk of D1853 accessing the netting was not high, the risk did exist – particularly as D1853 had put blades in his mouth on a previous occasion.

(c) There was an operational need to get D1853 off the wing in DCM Lyden's view – one which he was required to reach rapidly in a 'live' situation, and in respect of which he should be afforded some margin of appreciation to take account of the dynamic circumstances.

566. G4S therefore submits that, at the very least, staff were entitled to consider in the circumstances that force was a last resort, particularly given the repeated reassurances already given in respect of D1853's possessions – even if Mr Collier's second supplementary report shows that this is a matter in respect of which opinions could reasonably differ.

567. As he made clear in his second supplementary report, viewing the footage did not impact on paragraphs 443 and 444 of Mr Collier's original report, namely that:[929]

> "443. Necessary, reasonable, proportionate- all descriptions lead me to state all force met the general principles. I am unable to comment if the PIT was applied for the correct period.

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[927] INQ000177_0010, para 39

[928] INQ000177_0010, para 40

[929] INQ000111_0106

> 444. No more than was necessary- the head support was initially removed and then re-applied when attempting to head-butt staff. The force used was no more than necessary in the circumstance."

568. In relation to the possible application of a PIT, G4S submits that the Inquiry should not find that this was applied (and certainly not inappropriately). Mr Collier ultimately stood by his conclusion in paragraph 443 and in his second supplementary report opined that "*it is impossible to clarify if PIT were used*".[930] If anything, the evidence available suggests that there was no intention to cause pain: Mr Collier points out after having seen the footage that: "*The wrist of D1853 is flexed but there is no indication of the wrist being flexed to cause pain*" (emphasis added) and points out that when D1853 mentioned that he wanted the left wrist to be eased off, this was done by staff.[931]

569. Ultimately, therefore, this was an incident in respect of which the 'general principles' of necessity, reasonableness and proportionality were met in Mr Collier's view. There is some legitimate scope for disagreement as to whether, taking the circumstances in the round, when force was applied it was done as a last resort (given earlier discussions with D1853 during the incident), or whether further attempts at persuasion should have been made. G4S invites the Inquiry to recognise this and to afford DCM Lyden the 'benefit of the doubt' in the situation, or at least to recognise that he reasonably considered force to have been used as a last resort (even if the Chair ultimately disagrees that objectively it was) – in particular taking into account the need for DCM Lyden to take a decision 'in the moment' during a live incident, seeking to balance and mitigate all possible risks to D1853, staff and property.

Row 41: Medical incident involving D149 on 15 June 2016

570. This incident concerns D149's severe response to a spice attack – quite possibly the combination of spice with another drug. His reaction was so severe that an ambulance needed to be called.

571. The focus of the Inquiry's consideration of this incident appears to be (from the SoI), Callum Tulley's allegation that during the course of the medical response, staff were making inappropriate comments and laughing.

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[930] INQ000177_0010, para 43

[931] INQ000177_0010, para 41

572. The Inquiry has the benefit of both transcripts of the underlying footage;[932] as well as Mr Tulley's corresponding video diaries.[933] Mr Tulley does not identify which staff members he alleges acted inappropriately. Arguably, that alone is a basis on which the Inquiry should refrain from making adverse findings, as it would be unfair to do so: (a) in the absence of the relevant staff members being able to respond to the allegations directly put to them; and/or (b) in such general terms: G4S, for example, is entitled to understand the particulars of any suggestion of misconduct by its staff, to enable the Company to investigate the matter properly and make submissions accordingly.

573. In any event, even in his own video diary, when Callum Tulley was expressly asked what 'jokes' the staff were said to have been cracking during the incident, he could not recall what these were – even relatively shortly after the incident: "*I can't remember. Yes, I can't remember any of the jokes. Sorry, mate. It was just general laughter really sort of thing*".[934]

574. More than that, however, the Inquiry has the benefit of the undercover footage[935] and the transcripts thereof.[936] These do not provide any corroboration for the contention that staff made inappropriate comments or jokes; or that staff were laughing during the course of a serious medical emergency. To compound the point, the Inquiry also has the witness evidence of Dan Small;[937] and Nathan Ring[938] – neither of whom identify any inappropriate comments (and the latter positively denies doing so).

575. In short, this was a tragic incident of a severe overdose, in relation to which medical staff were so concerned that an ambulance was called. However, there is no reliable or meaningful evidence that staff acted inappropriately or laughed during the incident. On the contrary, the video footage demonstrates the seriousness with which it was taken by all staff – medical and custodial alike. The suggestion that there was any inappropriate comments or laughing is ultimately one made only by Callum Tulley in a video diary and, when pressed, he could identify a 'jokes' that were made – only generic laughing, which is not supported or corroborated by the underlying footage/transcripts. G4S submits that the Inquiry cannot

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[932] TRN0000093_9-23

[933] TRN0000069_4-7

[934] TRN0000069_7

[935] V2017061500014, V2017061500015, V2017061500016

[936] TRN0000093_9-23

[937] BDP000003_0018, para 56

[938] MIL000001_0018-19, paras 70-72

realistically make any finding of inappropriate conduct by staff in the manner suggested in Mr Tulley's video diary.

Row 43: Medical response called to a spice attack on 19 June 2017

576. This is an incident seemingly not addressed at all in the witness evidence before the Inquiry – in written form or during the oral hearings. (save for one passing refernce).[939] There is also extremely scant documentary evidence available to the Inquiry in relation to it. It is thus unsurprising that the SoI, itself, is unclear as to which detained persons the incident relates. In those circumstances, G4S' primary submission is that no findings can realistically be made by the Chair in relation to it.

577. In the alternative, the primary source of information available to the Inquiry is the transcript of some undercover footage filmed by Callum Tulley.[940] G4S has identified a further document which seems to suggest that the detained persons concerned were D232 and D612 (c.f. the footage transcript which refers to D3902): a SIR written by DCM Dean Brackenridge.[941] It does not support any allegation of inappropriate comments made by staff.

578. The footage transcript is seemingly, therefore, the only relevant document available to the Inquiry, however, G4S submits that it does not disclose evidence of staff making sarcastic or teasing comments towards the detained person. Notably (unlike other incidents caught in the footage), Callum Tulley did not consider this incident worthy of inclusion in either one of his video diaries or one of his own witness statements. On the contrary, the transcripts provide numerous examples of staff acting in not just a respectful but a caring manner towards the detained person. By way of just a few examples:

    (a) "*... do you want to stand up? We'll take you down to E wing just to chill a bit, just keep an eye on you, yeah? Come on, buddy, hold my hand. Up you get.*"[942]

    (b) "*Sit down, my friend. Come on.*"[943]

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[939] Sandra Calver 1 March 2022 146/14-24

[940] TRN0000083_3-12

[941] CJS004931

[942] TRN0000083_0006

[943] TRN0000083_0009

(c) *"I'm going to take you somewhere where you can sleep, yeah?"*[944]

579. G4S accepts – as did Sandra Calver[945] - that comments made by the nurse to the effect of *"Let's open your eyes. Oh, like saucers. That's what we like. You've had a good old time, haven't you? Was that fun? You enjoyed a good time. I think you enjoyed your stash"*[946] were inappropriate. In the absence of detailed evidence or examination, however, G4S submits that little can be made of that observation. The Inquiry has not heard from the nurse who made the remark. While her choice of language is poor, the levity of her words do not appear to disclose any intent to mock or demean. Rather, she appears, from context, to be responding to the positive development that the detained person's eyes were responsive in a manner that she had hoped ("*that's what we like*"). It may be, for example, that the light-heartedness of the phrase "*you've have a good old time*" was, whilst inappropriate, reflective of the nurse's relief at that responsiveness.

580. Ultimately, this was a one-off throwaway remark, with no intent to cause hurt or disrespect, even if the choice of words at the time in poor. It should be seen in the wider context of the incident in which the nurse provided the detained person with professional care in the course of a spice attack. It is that professional and diligent care which properly characterises the incident and demonstrates that no harm or hurt was meant by the nurse's one off-colour remark.

Row 44: Use of force against D1747 on 20 June 2016

581. This use of force was canvassed little during the course of the Inquiry's oral hearings (not including the reading-in of D1747's evidence, which took the form of summarising contemporaneous documents, rather than adducing a statement provided to the Inquiry by D1747, accompanied by a statement of truth).[947] Importantly, it would not be fair for the Inquiry to make any factual findings on this incident adverse to Derek Murphy, in circumstances in which the Inquiry did not explore the incident with him in the course of his oral evidence or challenge his written evidence to the Inquiry on the matter, denying hitting

[944] TRN0000083_0011

[945] Sandra Calver 1 March 2022 146/14-24

[946] TRN0000083_0005

[947] See Mohammed Khan 24 March 2022 40/15-46/5

D1747, but accepting he used a "*defensive action*" to get the detained person away from him.[948]

582. G4S submits that given the key relevant material in relation to this incident is primarily documentary (as well as the video footage),[949] the Inquiry should accept the conclusions of both the PSU in relation to this incident, as well as Mr Collier's observations on the use of force.

583. The PSU's conclusions are reasoned and sound in ultimately finding the complaint unsubstantiated.[950] G4S invites the Inquiry to accept these, particularly as they address the trigger or start of the incident, which occurs slightly off-camera in the CCTV footage. In particular:

(a) Derek Murphy's account was that it appeared to him that D1747 had only pretended to take his medication and concealed the pills in his left hand. That was why he approached D1747. His account was supported by the statements from DCO Brown, DCO Mayne and another detained person, D71.[951] In particular, DCO Maybe stated that she heard Derek Murphy ask D1747 to take his medication, supporting Derek Murphy's account that he thought D1747 had not taken these.[952]

(b) D71 did not believe that Derek Murphy had done anything wrong as D1747 "*got in his face unnecessarily*".[953]

(c) The CCTV evidence supported the contention that D1747 became "*angry and aggressive... It also confirms that Mr D1747 put his head forward with his face close to DCO Murphy's whilst appearing to shout at him*".[954]

(d) Derek Murphy was justified – based on the wider evidence and CCTV – in believing that D1747 was about to attack him. He was thus justified in his use of force, and the

[948] INQ000121_0011, para 41(b)

[949] Disk 08 20June2018 0813

[950] HOM003522_0015-0017, paras 7.3.1-9.3.14

[951] HOM003522_0014, para 7.2.20

[952] HOM003522_0015, para 7.3.2

[953] HOM003522_0010, para 6.5.3

[954] HOM003522_0016, para 7.3.5

CCTV indicated that "*the level of force used was of a magnitude sufficient for its purpose but does not appear excessive*".[955]

(e) Additionally, doubt is cast on the veracity of D1747's account given his accusation that Derek Murphy threw D1747's ID card at his feet, while the CCTV evidence shows that he "*clearly did not do so*".[956] Of course, the Inquiry was unable to test D1747's account by reference to this error since he did not give live evidence.

(f) Ultimately, "*all the available evidence, from witnesses and CCTV recording, tend to support DCO Murphy's account of proceedings…Available evidence supports his conviction that Mr D1747 constituted a threat and was justified in pushing him back, out of his personal space*".[957]

584. Additionally, Mr Collier's analysis is a helpful on the appropriateness of the force used by Derek Murphy. He observed and opined:

(a) There is obviously some communication between D1747 and Derek Murphy, "*and D1747 then turns and moves toward DCO Murphy, ending up with the pair in close proximity, generally termed as nose to nose'. DCO Murphy then uses both hands to push D1747 away, after which the pair come together again and a second push is used. After this a detainee intervenes and positions himself between them*".[958]

(b) "*The facial expression and body language of D1747 could be described as aggressive, he was stood square on within the personal space of DCO Murphy. DCO Murphy then uses a pushing action toward the torso to move D1747 away*"[959]

(c) "*Creating distance by either stepping away or using low level force or tactile distances are reasonable options…I believe DCO Murphy used reasonable and proportionate force to create a safe distance between them [in relation to both pushes]*".[960] This was the case, notwithstanding that the push was delivered with clenched fists.[961]

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[955] HOM003522_0016, para 7.3.7

[956] HOM003522_0016, para 7.3.9-7.3.12

[957] HOM003522_0017, para 7.3.13

[958] INQ000111_0116, para 491

[959] INQ000111_0117, para 493

[960] INQ000111_0117, para 494

[961] INQ000111_0117-0118, paras 495, 502; INQ000158_0031-0032, para 11.5

585. In summary, therefore:[962]

> "504. Last resort- DCO Murphy reacted to threat and had no opportunity to use other options, such as withdraw, or retreat.
>
> 505. Necessary, reasonable, proportionate- It was a necessary UOF to move D1747 and the two pushes, delivered at separate times, amount to a proportionate response to the threat at the time.
>
> 506. No more than was necessary- Low level technique that no more than necessary at the time."

586. All the evidence in this matter tends to support the account of Derek Murphy[963] and the conclusion that his actions were justified and proportionate in response to D1747 invading his personal space in an intimidating manner. D1747 was clearly aggrieved by the incident, but as the PSU report observes, aspects of his account appear "*clearly*" not to be true. He did report the incident to Sussex Police, who concluded "*no crime and this will not be investigated*".[964] The only reasonable conclusion for the Inquiry to reach on this incident is ultimately that shared by the PSU and Mr Collier: Derek Murphy's actions on this occasions were justified and appropriate.

Row 45: Comments made in a staff room on 20 June 2016

587. These comments made (primarily by Nathan Harris) were picked up in footage filmed undercover by Callum Tulley.[965] There can be no real dispute regarding what was said, as it is recorded in the transcript. From context, the officers appear to be discussing hypothetical means of transferring or removing detained persons by reference to the film *Con Air*.

588. What is said includes comments such as: "*masking tape, bag 'em*" and "*we should just got back to putting them to sleep* [mimes injecting himself]" and "*get the gas, chuck it in there, they're all knocked out [inaudible] needle in, he wakes up fucking wherever*".[966] All of these

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[962] INQ000111_0118-0119

[963] See also his UoF report after the incident, which is consistent with the PSU's findings: CJS005621

[964] SXP000055_0003

[965] KENCOV1038: V2017062000008; TRN0000084_10

[966] TRN0000084_10

comments were made by Nathan Harris; all are unprofessional and unacceptable. G4S were not made aware of these comments at the time.

589. Nathan Harris' evidence is that these comments were a "*a joke, which I accept to be inappropriate*"; and "*it does not look good and it may have resulted from naivety*".[967] He explains the wider 'context' as his having been injured on a number of occasions during removals because of the behaviour of detained persons, including once when his ribs were broken.[968] The implicit suggestion is that colleagues were discussing various ways in which detained persons could be restrained or subdued during removals in light of the frequency of agitation or refractory behaviour during them. Ultimately, though, Nathan Harris accepted that his words were "*inappropriate and I am embarrassed that I have made a comment like this*".[969] The fact that the conversation entailed staff joking around (rather than anything more serious) was accepted by Callum Tulley, who stated in oral evidence that: "*this is the kind of stuff that was seen as banter*".[970]

590. Nathan Harris' is part of a pattern of – no doubt honestly given – evidence that making inappropriate jokes was "*a control mechanism to deal with the difficult situations we face*", especially as staff found it difficult or impossible for non-IRC employees to understand life or the pressures inside an IRC.[971] Nevertheless, it is G4S' clear position that such comments are not acceptable, even if they were only made between colleagues and not in front of detained persons (although it would obviously be worse if they were made to or front of a detained person because of the possible effect it could have on them). Sean Sayers in his oral evidence rightly agreed that this was not an acceptable way to talk about detained people.[972]

591. In his notes;[973] and witness statement;[974] Callum Tulley suggests that additionally during the course of this conversation Andy Jennings "*made a gesture with his hand to indicate that he would shoot [the detained persons]*". That alleged gesture does not appear in the video

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[967] SER000432_0018, paras 93-94

[968] SER000432_0018, para 92

[969] SER000432_0018, para 92

[970] Callum Tulley 2 December 2021 87/24

[971] SER000432_0019, para 96

[972] Sean Sayers 10 March 2022 178/2-4

[973] CPS000025_0035

[974] INQ000052_0046, para 183

footage; nor is there any further evidence to corroborate (or refute) this claim. In particular, the Inquiry has not obtained any evidence from Andy Jennings, to enable him to give his response to Mr Tulley's accusation. If it were substantiated, the conduct would be unacceptable, too, but G4S submits that in the absence of corroboration from the footage as well as the Andy Jennings not having had an opportunity to respond to Callum Tulley's allegation, the Inquiry should not make any findings in relation to this aspect of the incident.

592. Overall, this incident relates to comments which were unprofessional and unacceptable. They were not, however, conduct towards or even in the presence of, detained persons and, as a result, cannot, themselves, constitute a breach of any person's Article 3 rights.

Row 46: Allegation that DCM Tomsett made homophobic comments to D1538 on 28 June 2017

593. This is a further incident in relation to which there is little evidence before the Inquiry. In fact, there is little more evidence beyond the two competing accounts of the detained person and the relevant staff member. It was also an allegation investigated by the PSU and not substantiated. As explained below, G4S invites the Inquiry to take a similar approach to that adopted by the PSU: in light of the competing accounts given by D1538 and DCM Tomsett, to note that what additional evidence there is – circumstantial though it may be – 'tips the balance' in favour of finding that DCM Tomsett did not in fact make these comments. Certainly, G4S contends that there is not a sufficient basis for the Inquiry to include on the balance of probabilities that the comments were made: it could be no higher than a 'suspicion': all the more so where, of the complainant and the officer, it was only the latter whose evidence was tested in oral examination during the course of the Inquiry's hearings.

594. D1538's account is set out in his complaint to the PSU, namely that on 28 June 2017 he attempted to enter C-wing where another detained person had offered him clothes to wear, as he only had a t-shirt and some shorts to wear. He alleges that DCM Tomsett (then a DCO) prevented him from entering C-wing and told him that "*he needed to change his clothes as he 'looked gay'*"; D1538 reacted angrily and was given a written warning for his behaviour.[975]

[975] DL0000231_0024, para 89

595. By contrast, DCM Tomsett denies having made any such remarks to D1538. He did so in his written statement;[976] and stood by this in his oral evidence to the Inquiry.[977]

596. In light of those competing accounts, G4S invites the Inquiry to consider the circumstantial evidence, as the PSU did:[978]

(a) D1538's account to the PSU was that he was seeking to enter C-wing to obtain clothing from another detained person as he only had t-shirts and 'boxer'-type shorts; and that no clothing had been issued to him.[979] However, there was evidence that D1538 had been issued 'destitute clothing' on admission, which would have included jogging bottoms and a jumper; and there was further evidence (including CCTV footage) demonstrating that D1538 had other clothes, including shorts other than boxer shorts.[980] This point undermines the credibility of D1538's account.

(b) It is common ground that D1538 became agitated,[981] and, in light of the doubt cast on the reason for his attempted entry (see immediately above), that agitation may well have been caused by the denial of entry to C-wing, itself, rather than any comments made by DCM Tomsett.

(c) It is also right to note in the context of the credibility of D1538's account so long after the event (given that his witness statement to the Inquiry was made in February 2022 and his PSU complaint was, itself, made almost two months after the event on 21 August 2017) that D1538 told the PSU that he "*could not remember what the officer had said as his memory was damaged and he could not always remember things*".[982]

597. In the premises, G4S respectfully submits that in the Inquiry cannot reliably conclude that DCM Tomsett did make the remarks alleged.

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[976] INN000024_0055, para 179

[977] Darren Tomsett 7 March 2022 58/11-60/6

[978] See CJS003348_0021-0022, paras 7.3.8-7.3.20

[979] CJS003348_0021, para 7.3.12

[980] CJS003348_0022, para 7.3.13

[981] See CJS001403_0032

[982] HOM002627_0004

Row 47: Use of force against D2054 on 28 June 2017

598. This incident is a further use of force in which – despite the incident not featuring significantly in the course of the Inquiry's oral hearings – the Inquiry has the benefit not only of the underlying footage;[983] and the officers' UoF reports;[984] but also the observations of Mr Collier;[985] as well as the conclusions of the PSU.[986] The Inquiry did not hear live evidence from any of the participants in the use of force (save for Derek Murphy), including D2054; but did receive written witness evidence from both DCM Aldis[987] and DCM Shadbolt.[988]

599. G4S makes its submissions on this incident by reference first to the observations of Mr Collier, which it accepts and invites the Inquiry to endorse (save as otherwise identified below). Mr Collier's key observations on the footage and documentation are that:

(a) D2054 was informed that he was being moved to a charter flight and "*refused all instructions from DCM Aldis to walk to the discharge area… He resisted the attempts by staff to take control of him… Throughout the movement D2054 was shouting and continued to resist staff*".[989]

(b) The briefing given by DCM Aldis covered all of the necessary information;[990] he "*makes every reasonable effort for D2054 to walk without the need for force being used*".[991]

(c) "*DCM Aldis explains the situation and give[s] several opportunities for D2054 to comply with the instruction. I am satisfied that he made all reasonable efforts to manage the incident without using force and as a last resort deployed staff to forcibly remove D2054*".[992]

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[983] Disk 25 28June2017 2319; Disk 26 20170628222251_E2047N_0007; Disk 26 20170628221925_E2047N_0006; Disk 27 28June2017 221

[984] HOM002385

[985] INQ000111_0074-80, paras 295-321; INQ000158_0008-0009, paras 1.3-1.4

[986] CJS005991_0019-0025, paras 7.4-7.6.6

[987] INQ000181_0019, para 90

[988] SER000441_0019-0020, paras 129-135

[989] INQ000111_0074, para 295

[990] INQ000111_0074, para 296

[991] INQ000111_0074, para 297

[992] INQ000111_0077-0078, para 307

(d) The staff enter at pace – which would replicate training and is reasonable in order to prevent harm.[993] D2054 is restrained in the supine position and leg control is also used, but "*quickly released*". Handcuffs are applied while D2054 is in the seated position – a technique that has been removed from the training syllabus because of the risk of chest compression. D2054 continually shouts 'Jesus' and is agitated by having to be escorted.[994] At no point did Mr Collier observe any indication that D2054 could have become unconscious.[995]

600. Mr Collier is right to point out that the BWVC footage is not, and should have been, pixelated. G4S accepts this. Mr Collier did recognise, however, that for the most part the camera focuses away from the restraint when D2054 was naked.[996] A towel was swiftly used to cover his modesty; and DCO Simmons' evidence is that he walked with the team as part of the transfer, specifically to hold it in place.[997] It should be noted that the transfer took place after lock-up and so when D2054 walked through the centre, there were no other detained persons around.

601. Mr Collier concluded that force was used as a last resort ("*All attempts for D2054 to comply with the instruction to move and due to his failure to comply the last resort was force being used*");[998] and that "*in the first instance force was necessary to carry out the removal and the techniques used reasonable in the circumstance[s]*".[999]

602. He did, however, have certain concerns:

603. First, he makes the observation that no consideration was given to the removal of any PPE during the course of the transfer.[1000] In relation to this criticism (which Mr Collier also makes in relation to other UoF incidences), G4S repeats its submissions above – namely that the wearing of 'complete' PPE for the use of force is expected by PS0 1600, which has no expectation for any of the equipment to be removed during the course of an incident. Mr Collier may well be correct that doing so could have de-escalating effects, but it is

[993] INQ000111_0078, para 308

[994] INQ000111_0075, para 300

[995] INQ000111_0078, para 308

[996] INQ000111_0075, para 297

[997] CJS005991_0013, para 6.3.4

[998] INQ000111_0079, para 317

[999] INQ000111_0079, para 318

[1000] See, e.g., INQ000111_0078, para 310

respectfully submitted that it is not consistent with the PSO, as it currently provides. It is a matter for the Chair whether she wishes to make any recommendations in respect of the PSO in light of Mr Collier's observations.

604. G4S accepts Mr Collier's criticism that the practice of handcuffing in the seated position should be withdrawn;[1001] indeed it already has: as he points out, that technique is no longer trained. However, it is right to point out that it was the "*standard procedure at the time*".[1002] Similarly, G4S can see the logic in Mr Collier's suggestion that UoF paperwork and video filming should also being undertaken by the escort contractor.[1003]

605. Perhaps the key criticism made by Mr Collier is that during the course of the transfer, certain restraints ought to have been removed – for example the gloves of the head support officer;[1004] as well as full restraints.[1005] This leads Mr Collier to the conclusion that in respect of the continuation of those particular restraints [only] (e.g. the ongoing head support once handcuffs had been applied), such force was "*no longer necessary*".[1006] He clarified this in his first supplementary report, explaining that this would typically be described as "*not being necessary or reasonable*" rather than "*excessive*".[1007]

606. Respectfully, G4S invites the Inquiry not to accept this particular criticism made by Mr Collier, which is predicated on control having been gained, such that D2054 "*no longer presented a risk*".[1008] In his own report, he recognised that: "*throughout the movement D2054 was shouting and continued to resist staff*";[1009] which also echoes a finding made by the PSU that: "*D2054 was shouting 'Jesus' throughout, resisting the officers by moving his arms and legs about pre the application of the handcuffs and pushing back and shouting whilst walking to reception*" (emphasis added).[1010] That is why the PSU found the use of

[1001] INQ000111_0078, para 312

[1002] SER000441_0020, para 131

[1003] INQ000111_0078, para 313

[1004] INQ000111_0078, para 311

[1005] INQ000111_0079, para 318

[1006] INQ000111_0079, para 318-321

[1007] INQ000158_0008-0009, paras 1.3-1.4

[1008] See, e.g., INQ000158_0009, para 1.4

[1009] INQ000111_0074, para 295

[1010] CJS005991_0024, para 7.5.11

force to be "*proportionate to the seriousness of the circumstances*".[1011] Accordingly, it is not the case that once D2054 was in handcuffs, the officers were completely in control with no further risk posed by the detained person. On the contrary, he continued to resists, as the PSU observes; and the very fact – as shown clearly by the footage – that he continued to shout 'Jesus' repeatedly (almost non-stop) and swear, demonstrates his continued agitation and the ongoing risk. Indeed, in his evidence to the Inquiry, Ben Shadbolt points out that de-escalation was considered but "*it was not possible to use any de-escalation techniques during this incident as D2504 was non-compliant throughout the whole incident*".[1012] The continued head support, for the safety of D2054 and staff was, it is submitted, reasonable in the circumstances. Indeed, the evidence shows that staff were mindful that any restraints which were no longer necessary once handcuffs were applied should immediately be released. This occurred in relation to the leg restraint, which (as noted above), Mr Collier observed; and it is also contained in DCO Di-Tella's UoF report: "*I heard DCO Shadbolt asking for the handcuffs to be applied and shortly after DCM instructed me to release my hold*".[1013]

607. In the alternative, if the Chair is minded to agree with Mr Collier's observations in this regard, G4S submits that the continued use of these narrow and particular restraints – in the context of an otherwise lawful and necessary handcuffing and forced transfer – would have had very little, if any impact on D2054, and in particular his dignity. To the extent he was distressed by the event, that was inherent in the nature of a forced, handcuffed transfer; not the additional application of a head support.

608. It was suggested in oral evidence to Chrissie Williams that since she had referred D2054 for a mental health assessment on 26 June, two days prior to his removal, this should have been arranged urgently prior to 28 June.[1014] However, that ignores the point that Tascor received the 'fit to fly' authorisation on 27 June 2017 – i.e. a separate authorisation (presumably by a doctor) was given *after* Chrissie Williams had requested a further mental health assessment.[1015] More than that, CTI stated to Chrissie Williams that: "*by this time [28 June] no mental health assessment had been carried out*", then asking "*it should have been,*

[1011] CJS005991_0024, para 7.5.11

[1012] SER000441_0020, para 134

[1013] HOM002385_0013

[1014] Chrissie Williams 10 March 2022 111/6-112/23

[1015] HOM002408_0008

shouldn't it?"[1016] However, D2054's medical records show that a mental health nurse (Daliah Dowd) in fact saw D2054 on 27 June, after Chrissie Williams' request, "*following referral*".[1017] It was thus not right or fair to suggest to Chrissie Williams that she had, in essence, let D2054 be subject to the use of force and transfer after having requested a mental health assessment, but without it having taken place. G4S further submits that no reliance should be placed on Chrissie Williams' evidence following this line of questioning,[1018] in which the witness was cross-examined by CTI: propositions were pressed on her where the expected response was 'yes', rather than eliciting her best evidence through open questions. A further example is CTI asking Ms Williams if she considered checking with the detention staff whether the maintain of the force throughout was necessary;[1019] when the footage shows that detention staff in fact turned round during the transfer to check whether (seemingly) medical staff were happy for it to proceed. Equally, CTI asked Ms Williams if she considered "*the treatment, particularly that he was naked, to be degrading*":[1020] D2054 was not naked, there was a towel wrapped around him for the sake of his dignity. That was an important detail when it comes to the question of D2054's dignity during the incident. Indeed, DCO Simmons told the PSU that he specifically "*walked with the team and D2054 [as part of the transfer] so that he could maintain a hold on the towel around D2054*".[1021] Plainly, the detained person's dignity was an important consideration for staff.

609. For completeness, G4S further invites the Inquiry to accept the conclusions reached by the PSU, including and in particular in relation to Allegations 4-6, for the reasons contained therein.[1022]

Rows 48 and 49: Two uses of force against D87 on 30 June 2017

610. These two incidents occurred in relatively short succession (although involving different staff); both in relation to D87 – the first his transfer from E wing to the CSU and the second

[1016] Chrissie Williams 10 March 2022 112/17-23

[1017] HOM002389_0002

[1018] Chrissie Williams 10 March 2022 112/23-116/1

[1019] Chrissie Williams 10 March 2022 114/22-24

[1020] Chrissie Williams 10 March 2022 114/17-18

[1021] CJS005991_0013, para 6.3.4

[1022] CJS005991_0019-0025, paras 7.4-7.6.6

to unblock the observation panel in D87's room on the CSU and to remove any items with which he could self-harm.

611. Although there is a relatively substantial amount of underlying documentation in relation to these incidents, they can be addressed relatively swiftly in submissions – principally because there can realistically be no real suggestion that the force used on either occasion was seriously problematic or, more broadly, that there was any mistreatment of D87 within the Inquiry's ToR. On the contrary, these were incidents in which some staff were injured by a refractory and, at times dangerous, detained person.

612. G4S' submissions on this pair of incidents are principally guided by the observations of Mr Collier – as an expert on the use of force, to address the appropriateness of the force used by staff. In addition to addressing (and chiefly relying upon) Mr Collier's conclusions and observations, G4S' submissions will be made by reference to aspects of the PSU's conclusions, following its detailed investigation – in respect of matters alleged but not falling within the rubric of use of force (chiefly the alleged delay before responding to a suggestion of self-harm).

613. Starting, then, with the observations of Mr Collier, who addresses both incidents together in his report. It is also worth pointing out that both the Inquiry and Mr Collier had the benefit of handheld video footage in relation to both incidents.[1023] This is not an incident where Mr Collier had to rely solely on staff accounts contained in UoF reports (which are open to claims of being self-serving, etc.). Rather, he came to his clear conclusions on the basis of clear footage.

614. In relation to the first incident, Mr Collier observed that:

(a) The initial authority to remove D87 to the CSU was lawful and correct in light of the serious threats he had made – which included hostage taking.[1024]

(b) It was "*clear*" that DCM Brackenridge had tried to persuade D87 to comply voluntarily; and once the latter became confrontational, further attempts to seek compliance failed.[1025]

(c) "*The staff only attempted approved techniques but struggled to gain control due to D87 actively resisting their attempts. The force used was reasonable and*

[1023] See the references at footnotes 100-108 of Mr Collier's report: INQ000111_0081-0082

[1024] INQ000111_0082, para 325

[1025] INQ000111_0082, para 326

proportionate in the circumstances, but proved ineffective as times due in some part to the physical stature of D87 and by staff being unable to gain any sort of control of his arms."[1026]

(d) D87 manages to push an officer into a wall: throughout staff do not apply the head support position and control D87 only by his arms, without the application of handcuffs.[1027]

(e) "*Considering all of the risk and the levels of strength and potential violence it was correct to maintain control and it was unfortunate that two staff were injured during what was a particularly difficult situation to manage. The force used was appropriate, but I would question why handcuffs were not applied and why the head support position was not use during the move to the CSU.*"[1028]

615. In relation to the second incident, Mr Collier observed that:

(a) DCM Robinson explained what was required from outside the room but D87 did not respond. Staff enter with a shield and remove a ligature and items of risk. "*Throughout DCM Robinson tries to calm the situation and demonstrates good control of the situation. Once all of the items are removed staff are instructed to leave the room.*"[1029]

(b) Mr Collier specifically commented that:[1030]

> "The management and control of this situation were excellently performed by DCM Robinson. He demonstrated a calming but assertive presence and spoke politely and with clear explanation to D87. Considering the difficulties that staff encountered earlier it was the correct decision to equip staff with PPE and to take all reasonable precautions. Staff exited the room without using unnecessary force and the only force used was reasonable in order to eliminate the risk of self-harm by using the items in the room."

616. Overall, Mr Collier's conclusions were that:[1031]

> "346. *Last resor*t- During both incidents staff made numerous requests for D87 to comply with their instructions. As a last resort staff were deployed to enforce the instruction.

[1026] INQ000111_0082, para 326

[1027] INQ000111_0083, para 328

[1028] INQ000111_0083, para 330

[1029] INQ000111_0084, para 333

[1030] INQ000111_0084, para 334

[1031] INQ000111_0087

> 347. *Necessary, reasonable, proportionate* - Force was necessary to move D87 and all techniques were reasonable and proportionate to the threat, although not applied correctly. This was due to the struggle and resistance offered by D87. The second incident justified force to enable items of potential harm were removed from his room.
>
> 348. *No more than was necessary*- All force observed was necessary, and even when additional staff become involved it can be justified due to the problems encountered trying to gain control of D87."

617. He opined that "*the staff maintained total professionalism throughout and should be commended on their efforts*".[1032] At the same time he did point out that force used did not always accord with the UOF training manual – and staff adapted where they could. This was not a criticism of staff; and Mr Collier "*never felt D87 was in danger of sustaining any injuries*" – but ideally the stature of staff used for an incident such as this should match the detained person.[1033] This aligns with a constructive criticism raised by Mr Collier that certain techniques were applied incorrectly, which prevented staff from gaining control – and, for example, handcuffs should have been applied to assist with the restraint.[1034]

618. G4S endorses general Mr Collier's observations above and notes his additional confirmation of "*the facts and agree with the conclusion of the [PSU] investigating officer that no inappropriate action was evidenced by the staff and that there was a lawful right to move D87.*" It accepts his criticism that some techniques may have not been correctly executed by staff, but prays in aid Mr Collier's own recognition that this was "*due to the struggle and resistance offered by D87*". None of this, however, could possibly be said to amount to mistreatment of D87 by staff:

    (a) Mr Collier recognised that in terms that he never considered that D87 was at risk of sustaining any injury, notwithstanding any erroneous execution of technique (on the contrary, it was he who injured staff);

    (b) Mr Collier in fact suggests that more restrictive restraints should have been applied to D87 by staff – for example questioning the decision not to apply handcuffs, which he (from context) appears to have viewed as a misguided, if well-intentioned, attempt at de-escalation.[1035]

[1032] INQ000111_0085, para 339

[1033] INQ000111_0085, para 338

[1034] INQ000111_0086, para 343

[1035] See INQ000111_0083, para 330

619. There can be no doubt based on the above that these incidents did not entail any mistreatment of D87 through the use of force by G4S staff. Notably, not only did Mr Collier expressly commend both DCM Robinson, in particular, as well as staff generally for their conduct of a very difficult and trying incident, but so did the PSU, adding a special recommendation to the report:[1036]

> "All the officers involved in the two incidents should be commended for their dealings with D87 and recognised for their efforts during two particularly challenging and protracted incidents. It is evident from all the information obtained that D87 could be a difficult gentleman to deal with; and he was clearly a strong individual. In the circumstances all the officers remained professional and polite with D87; and treated him with respect, despite the manner in which he spoke to them."

620. As noted above, the PSU investigation was detailed and comprehensive, and G4S endorses and invites the Chair to accept its conclusions in Section 7.[1037] G4S does not set out here the PSU's analysis and conclusions in respect of the use of force in light of the expert opinion already set out above in relation to the same, but invites the Inquiry to read these in detail.

621. For completeness, there is one aspect of the complaint which is distinct to allegations concerning the staff's use of force on D87 – specifically that staff delayed for around 1½ hours before responding to what D87 said at the time was an attempt to take his life (but which he told the PSU was in fact seeking attention only). That allegation can be put paid to swiftly: the 'Record of Actions and Observations' demonstrates that D87 was on a constant watch while in the CSU, with staff regularly recording observations of him.[1038] These begin at 17:50, very shortly after the initial incident and his relocation to the CSU. The first reference at all to to D87 saying he would kill himself is recorded at 18:40.[1039] It is right that the team did not enter until 19:45. However, the PSU was right not to see anything problematic about this:[1040]

(a) The intervention was planned and it took time to assemble a team together in full PPE;

(b) "*All the time that D87 was shouting, screaming and making threats, it was not deemed necessary to enter his room*" (presumably as he evidently was not self-harming);

[1036] HOM003157_0034

[1037] HOM003157_0016-0034

[1038] CJS001419_0004

[1039] CJS001419_0004

[1040] HOM003157_0032, paras 7.98-7.100

(c) At all times staff had "*eyes on*" D87 through the gap in the window (and so could have intervened if he did look like he was going to self-harm;

(d) When, at 19:40, D87 changed his position to lying on the desk – this was an appropriate opportunity for staff to enter, given it would have been more difficult for D87 to react to staff entering.

622. Overall, therefore, this pair of incidents were examples of staff conduct where both Mr Collier and the PSU have separately called for their commendation, not censure. It gets nowhere near the 'line' for a case of mistreatment.

Row 50: Removal of a ligature from D865

623. The nub of this incident is whether – and, if so, why – Chris Donnelly (and Benjamin Opoku) delayed in removing a ligature from the neck of D865. The Inquiry can see the footage of the incident, itself;[1041] and read the transcript of the relevant part.[1042]

624. What is common ground is that Chris Donnelly and Benjamin Opoku were already on the scene when Callum Tulley arrived. The key contentious question is then why the ligature had not been removed by either person when Callum Tulley arrived. Callum Tulley has alleged that despite Chris Donnelly saying "*No. It's not round his neck*" (i.e. suggesting that he did not think there was a ligature around D865's neck, contrary to what Callum Tulley could see), "*I don't believe for one minute that he genuinely can't see the ligature*".[1043] As to why Chris Donnelly might deny being able to see the ligature, if he in fact could, Mr Tulley gives inconsistent answers: in his video diary he suggests apathy: "*it was if they didn't want to go and see if this detainee had killed himself or if he had harmed himself. They were just looking at this guy laying on the floor. They were showing no... [speaker adds: 'interest in going to see the guy']*".[1044] In his statement to the police, Mr Tulley suggested that there was actual malice: "*Chris Donnelly demonstrated hatred towards the detainees. I am sure he was intent on letting the detainee suffer*"[1045]; he repeated this in oral evidence.[1046]

[1041] KENCOV1043: V2017070400007

[1042] TRN0000033_0001-0002

[1043] TRN0000073_0004

[1044] TRN0000073_0005-0006

[1045] CPS000018_0008

[1046] Callum Tulley 2 December 2021 26/8-10

625. It is from Callum Tulley's video diaries and police statement that the allegation also emerges that Mr Donnelly may have left D865 with the ligature around his neck for up to two minutes. The source of that allegation is Mr Tulley's point that it was probably about two minutes from when the first response went off until he arrived at the scene and Chris Donnelly was the A and B wing manger that day.[1047] It should be noted that, in reality, Chris Donnelly was probably present for significantly less than two minutes before the ligature was removed: he came from A Wing and it took him around a minute to arrive at the scene.[1048]

626. Chris Donnelly's consistent account – to this Inquiry and to the G4S investigator – was that he genuinely did not see the cord around D865's neck. Callum Tulley does not believe that, but has offered no justification for his position beyond the fact that it was visible to him from the angle that he was standing. Consideration of the underlying footage suggests that it is, indeed, plausible that Chris Donnelly (and Benjamin Opoku) could easily have missed it. There are a number of either items lying or located near D865, and D865's neck is not completely visible. Indeed, when the cord appears on screen once cut, it is shown – consistent with Chris Donnelly's account – to be thin.

627. In the circumstances, the Inquiry is invited to accept Chris Donnelly's explanation. In part it should do so in recognition of the inherent plausibility of an officer seeing a ligature around the neck of an ostensibly unconscious (or close to it) detained person, and simply choosing to leave it there untouched – knowing that other staff, including healthcare, would shortly be arriving, and that if he had done this knowingly, he would likely have been reported and disciplined. Chris Donnelly's comments on the undercover footage are consistent with him coming to the realisation that there is a ligature once Mr Tulley has pointed it out: "*Is he – he's not charged[?] is he?*".[1049] It is at that point that he moves immediately to cut the ligature. Moreover, if Callum Tulley were right that the act were deliberate, one would expect his hypothesis to be supported by further behaviour or comments made by Chris Donnelly at the scene – which it was not.

628. G4S therefore stands by its investigatory conclusions that the allegations were substantiated – insofar as Chris Donnelly and Ben Opoku should have checked for a ligature and removed it; however they did not act with any intent to cause harm or distress to D865.[1050] The right

[1047] TRN0000073_0006

[1048] CJS005952_0004

[1049] TRN0000033_0002

[1050] CJS005952_0007

outcome was the 'advice and guidance' letter written to Chris Donnelly to remind him of the need "*to make a full assessment on arrival at a response incident to ensure that detainees are immediately safeguarded*";[1051] and a written warning to Ben Opoku – who, as the first staff member present should have administered first aid, notwithstanding that DCO Opoku had seen D865 speaking to his roommate (and thus assumed he was not in medical distress).[1052]

629. The crucial point is that while both officers Donnelly and Opoku failed to follow procedure – either or both officers should have checked for a ligature as part of emergency first aid, there is no real basis on which the Inquiry should – or could – conclude that either officer had seen the ligature and positively decided not to remove it. Rather, DCM Donnelly took over the scene from DCO Opoku (who then removed to the door); and it was Callum Tulley who brought the ligature to the officers' attention. Chris Donnelly quite rightly accepted these criticisms when giving his evidence to the Inquiry; "*I hold my hands up. I should have carried out the checks myself, but I didn't*" (rather than assuming DCO Opoku had done so as the first officer on scene).[1053] It should be pointed out that when he accepted in evidence that he did 'delay',[1054] it is clear that what Chris Donnelly meant by this was that there was a time lag between his arrival and the ligature being removed; not that he delayed removing it once he became aware of its existence. As he went on to explain: "*As soon as Callum mentioned that there was actually a ligature around his neck, I got my fish out -- fish knife out and removed it, but I accept that I didn't do what I should have done.*"[1055] Chris Donnelly's explanation as to why he did not include the fact that Callum Tulley had to point out the ligature to him from his incident report ("*probably because I didn't want to make myself look bad*")[1056] casts him in an unfavourable light, but reflects an honesty to his account to the Inquiry. He could have easily stated that he had forgotten or overlooked this point; or that it was too minor a detail to record – but he honestly stated that he did not want to come across unfavourably.

[1051] CJS0073302_0001

[1052] CJS0073449_0001

[1053] Chris Donnelly 23 February 2022 107/17-18

[1054] Chris Donnelly 23 February 2022 115/11-13

[1055] Chris Donnelly 23 February 2022 116/6-9

[1056] Chris Donnelly 23 February 2022 127/3

630. Ultimately, the two officers first on scene were remiss in their obligations to check D865 for signs of a ligature or self-harm as part of emergency first aid. That is certainly regrettable and a point that DCM Donnelly has accepted. Thankfully it had no impact on D865, himself, who recovered.[1057] Such an omission in protocol does not, though, violate Article 3. As the G4S investigator found, "*DCM Donnelly did not act with any intent to cause harm or distress to the detainee in relation to the removal of the ligature*".[1058] Rather, as soon as the ligature was pointed out to him, Chris Donnelly acted swiftly in removing it, and there is no evidence that the delay in him doing so had any deleterious effect on D865. This was an honest, inadvertent mistake.

Row 51: Comments made by staff to or about D728 on 6 July 2017

631. This incident concerns comments made by staff to or about D728 on 6 July 2018, primarily in an interaction between D728, Callum Tulley, Steve Webb and Charlies Francis on the CSU (some of which occurred outside D728's closed door, and which he would not have seen or heard).[1059]

632. The Inquiry has footage of this incident;[1060] and transcripts thereof.[1061] As a result, there can be little, if anything, in dispute about what actually was said. The key considerations for the Inquiry are therefore the appropriateness of the words used and – where those words may have been inappropriate – the evidence before it as to why staff conducted themselves in that way.

633. It is appropriate to consider this incident from the perspective of the conduct of each of the officers concerned: Steve Webb, Charlie Francis and Aaron Stokes.

634. During the course of the incident, Steve Webb said to D728 "*dick us about and we'll make your life a fucking misery*".[1062] The transcript also records Steve Webb has having said "*I'll fucking punch the cunt. I tell ya*".[1063] The footage shows, however, that this latter statement

[1057] Chris Donnelly 23 February 2022 127/5

[1058] CJS005952_0007

[1059] Steve Webb 8 March 2022 192/15-16; 198/9-10

[1060] KENCOV1044 - V2017070600007

[1061] TRN0000094; TRN0000017; TRN0000018

[1062] TRN0000094_0014

[1063] TRN0000094_0013

was not said in the vicinity of D728 (whose door appears to be closed at this point), supporting Steve Webb's evidence that: "*I did not call the detainee a "cunt" or a "twat" within his earshot and these are examples of me blowing off steam with colleagues*".[1064]

635. Even taking into account that the latter comment most likely could not be heard by D728, G4S considers neither comment to be acceptable. In fairness to Steve Webb, when the entire incident is viewed in the round, it is right to note that Steve Webb has given D728 a cigarette and told him to come to him in future if he has any problems.[1065] That demonstration of a positive rapport by the time D728 had calmed down may suggest that Steve Webb's earlier comments were, indeed, out of frustration and atypical, but it does not render them acceptable. It is right that Steve Webb accepted that he made these remarks when investigated by G4S – including a suggestion that if D728 "*piss[ed] us about… you will get no shower*".[1066] In relation to this latter comment, Steve Webb stated that it was in response to milk being thrown by D728 at Charlie Francis and Callum Tulley – a point corroborated by Callum Tulley's notes: "*D728 threw milk at Callum was abusive. Staff started to lose their call…* ".[1067] This suggests that staff frustration was responsive to the abuse received from D728. It is also right to note that in relation to the shower, Steve Webb had already said to D728 that: "*as soon as I've got the staff, you can have a shower*".[1068] That was not prevarication on Steve Webb's part. As he explained in evidence, D728 was particularly violent and it required three officers to let him out of his room.[1069]

636. Equally, it was not acceptable for Steve Webb to say to D728: "*Stop being a fucking idiot*".[1070] Steve Webb described this in evidence as a 'mirroring' technique to match the detained person's volume – something that had been discussed at the NTRG in Kidlington.[1071] As he seemingly went on to accept,[1072] that technique may have been reflected in matching a person's volume, but would not have entailed using swear words towards a detained person, as Steve Webb did. It was a comment made out of frustration

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[1064] MIL000003_0018

[1065] TRN0000094_0016-0018

[1066] CJS005936_0004

[1067] CPS000025_0037 (as well as the video transcript at TRN0000094_006).

[1068] TRN0000094_0013

[1069] Steve Webb 8 March 2022 194/23-25

[1070] TRN0000094_0015

[1071] Steve Webb 8 March 2022 201/1-4

[1072] Steve Webb 8 March 2022 201/6-18

against a refractory detained person, who was shouting angrily towards staff – however it should not have been said.

637. G4S gave Steve Webb a final written warning in relation to this conduct[1073] – which it stands by as the appropriate sanction. It reflects that Steve Webb's comments were seriously inappropriate; although the reference to the 'punch' was not made in D728's presence and without any intention to use violence on the detained person.[1074] It also takes into consideration Steve Webb's remorse, his frustration on the day and the fact that D728 was a particularly challenging detained person: he had been smearing faeces on his room window, thrown milk at staff, and as the footage shows, was getting increasingly agitated and irate towards staff. Nevertheless, G4S expects its staff to maintain professionalism at all times – even when facing abuse from detained persons, which is why Steve Webb received a final written warning for this conduct.

638. In the course of the incident, Charlie Francis said to D728 "*you won't go anywhere if you fucking carry on like this*"[1075] and in response to Steve Webb's reference to wanting to punch the detained person, said "*if you don't, I will*".[1076] He accepted that "*my comments were inappropriate and I should not have said what I said*"; and made clear that "*I had no intention of punching the detained person and I never would have done. This was highly inappropriate banter*".[1077] He also pointed out that the comment about punching the detained person was "*made to Steve Webb in a one-to-one conversation*" (i.e. not in front of D728).[1078]

639. In his evidence, Charlie Francis explained that his comments to D728 regarding the shower were an 'empty threat' and that all detained persons would receive showers; instead this was "*a method by which I tried to get the detained person to conform*".[1079] There is support for this point in the transcript, given Charlie Francis' earlier comment: "*somewhere in the next hour. Next hour, just after, cos at the moment we've got to find people. Alright? But you will get a shower*".[1080] This was echoed in Charlie Francis' oral evidence, where he

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[1073] CJS0073480

[1074] Steve Webb 8 March 2022 195/13-15

[1075] TRN0000094_0006

[1076] TRN0000094_0013

[1077] HOW000001_0017, para 14

[1078] HOW000001_0017, para 14

[1079] HOW000001_0017, para 14

[1080] TRN0000094_0005

explained that: "*I don't think I came across as threatening… It's all part of trying to get him to follow regime*".[1081]

640. G4S appreciates that Charlie Francis was in a difficult situation – given a disruptive and agitated detained person, but whose known history of violence meant that he was on a 'three-man unlock', which limited the officers' options at the time. However, G4S does not accept that in such circumstances – notwithstanding the absence of malign intent – that Charlie Francis should have said anything to even intimate that disruptive behaviour would be linked to preventing D728 from showering. It should be noted, however, that disruptive behaviour by a detained person could legitimately cause showering to be, for example, delayed. Following a violent outburst, it may be necessary to give a detained person a period of time to cool off – for the safety of themselves and staff – before enabling them to shower. Detained persons never lose the right to shower; but operational considerations can impact on exactly how that right is exercised – particularly where a detained person's conduct renders a larger team necessary to escort them to showering facilities.

641. That is why G4S found to be substantiated the lion's share of the allegations concerning this incident in respect of Charlie Francis (the small exception being where particularly words on a transcript had been misattributed).[1082] This incident also formed part of the gross misconduct charges that led to his dismissal.[1083]

642. The footage also records Aaron Stokes referring to D728 (in his absence) as, for example a "*bell end*"[1084] and an "*absolute cunt*".[1085] This is a conversation between Aaron Stokes and Callum Tulley in which Aaron Stokes describes D728 saying "*I'll hang myself, I'll hang myself*" and DCO Stokes continues: "*I don't really care. I don't care, just do it. He ain't gonna hang himself with his shorts*".[1086] From the reference to not being able to hang one's self with shorts and another comment made by Aaron Stokes ("*I'm bored of these empty threats*"),[1087] it is clear that Aaron Stokes is not showing a lack of sympathy for detained persons who he considered had a genuine intent on self-harming, but was getting frustrated

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[1081] Charlie Francis 3 March 2022 83/16-21

[1082] CJS005974_0011-0012

[1083] CJS0072973

[1084] TRN0000094_0054

[1085] TRN0000094_0047

[1086] TRN0000094_0054

[1087] TRN0000094_0055

by what he clearly considered to be 'empty threats' – repeated claims of a desire to self-harm, where there was, in fact, no real risk. Nevertheless, Aaron Stokes in evidence accepted that these words were not appropriate. He was right to do so:[1088]

> "I don't recall saying this , but if I did then I didn't mean anything by it and obviously would not have let him hang himself or hurt himself. I believe I was just under so much stress and just spurted off. Obviously these were not appropriate remarks."

643. These remarks from Steve Webb, Charlie Francis and Aaron Stokes are all unprofessional and unacceptable, in G4S' view – in light of the standards expected of staff. That is reflected in the disciplinary action taken towards both Steve Webb and Charlie Francis in relation to this incident. That does not mean, however, that any aspect of this incident amounted to an Article 3 breach. In that regard it is important to note that the most egregious conduct (suggestions, even if without 'intent', that an officer might punch D728) did not occur towards or in earshot of D728: it was highly inappropriate joking between staff that G4S does not condone. Equally, some regard must be had to the context: D728 was becoming increasingly irate, which caused natural frustration for staff – particularly as he had thrown milk over officers. This was in circumstances where D728's previous conduct meant that he was a 'three-man unlock' and the incident could not easily be resolved by using, for example, one member of staff to allow him to shower at that point in time. Staff were in the unavoidable but invidious position of not being able, without further support, to resolve the incident. Ultimately, however, Steve Webb managed – commendably – to get D728 into a position where he could offer him a cigarette and support. This was a case where staff should have de-escalated the situation, where their words may have contributed to increased frustration on all sides. It does not, however, amount to a breach of Article 3 – not least given the absence of any real evidence as to any serious effect on D728.

Row 52: Use of force against D1618 on 29 July by the airport escort guards

644. As is clear from D1618's own evidence,[1089] as well as the PSU's investigation into the incident,[1090] this concerns the escort of D1618 to the airport and towards the plane (including

[1088] INQ000132_0007, para 15

[1089] INQ000055_0007, paras 39-46; D1618 3 December 2021 19/1-23/6

[1090] CAP001005

the use of a waist restraint). It concerns conduct by TASCOR staff, not G4S employees and accordingly G4S makes no submissions in relation to it.

Row 53: Use of force against D642 on 3 August 2017

645. This incident concerns the unplanned use of force against D642 following an act of self-harm by another detained person on A Wing, during which a group of detained persons had gathered around the medical incident and D642 became abusive and threatening toward staff – including throwing water over them.

646. The Inquiry has the benefit of CCTV for this incident,[1091] as well as the observations of Mr Collier[1092] and the conclusions of the PSU.[1093] It has witness evidence from Steven Webb (written[1094] and oral[1095]); but none from D642.

647. In the circumstances, G4S' submissions on this incident in relation to the use of force aspect are given by reference to the observations and conclusions of Mr Collier – who also had the benefit of the CCTV footage (supplemented by Steven Webb's oral evidence). He observed:

(a) It was "*perfectly correct*" for staff to disperse the group of interested detained persons while medical attention was given to the injured detained person.[1096]

(b) DCO May takes hold of D462 and is assisted by DCM Yates in moving D642 towards a secure door; the officers lose control of D642, a struggle takes place and DCM Webb takes control of D642's head while staff re-assert control of the detained person. D642 went to ground and the restraints were removed. A pattern continues for 11-12 minutes in which D642 fluctuates from standing up, confronting staff and, lying down and sitting. Thereafter D642 is relocated to the CSU. [1097]

(c) His opinion was that:[1098]

[1091] Disk 14 03Aug2017; Disk 13 03August2017 1959

[1092] INQ000111_0050-0053, paras 191-213

[1093] HOM002694

[1094] MIL000003_0019, para 13(e)

[1095] Steve Webb 8 March 2022 154/4-163/2

[1096] INQ000111_0050, para 194

[1097] INQ000111_0051, paras 195-197

[1098] INQ000111_0051-0052, para 199

> "This incident seemed to escalate very quickly and the staff did well in removing D642 when faced with the challenges of a full wing of detainees. The force used initially appears reasonable and proportionate, if they assessed the behaviour of D642 was a risk to staff and they had no other option of managing him…based on what I could observe staff do appear to have used authorised techniques that were proportionate to the circumstances".

(d) Staff followed the medical guidance to release restraints when D642 complained of 'not breathing'; and there was no visual evidence of Steve Webb grabbing D642 around the neck.[1099]

648. An important aspect of Mr Collier's analysis is the fact that staff reacted to D642 throwing water over a colleague. As he states:[1100]

> "209. *Last resort* - Staff reacted to the throwing of water over a colleague. It is not evident from the reports if D642 continued to offer a threat.
>
> 210. *Necessary, reasonable, proportionate* - Necessary would depend on whether there was a further risk after the throwing of water. If so force would be necessary, if not then force would not be necessary. It was a proportionate response to use the techniques described to move from the wing.
>
> 211. *No more than was necessary* - All restraints were removed when D642 complained about not being able to breathe. After the restraints were removed no force was used."

649. Further:[1101]

> "If the throwing of water was a potential start of further threats to staff then using force would be the appropriate. If it was a solitary action the risk of harm was no more than getting wet. DCM Webb states it was hot water, DCO May makes no comment over the water temperature. If it was hot I would have expected him to record the feeling of hot water on him."

650. Accordingly, the question of the risk associated with the throwing of water is an important aspect of the question of whether force was used as a 'last resort' and whether it was 'necessary'. Note, however, that is not the same as the narrow, factual question of whether the water was hot or cold; but rather what risk staff perceived to come from the throwing of the water.

[1099] INQ000111_0052, para 200

[1100] INQ000111_0053

[1101] INQ000111_0052-0053, para 204

651. Steve Webb was asked about this in his oral evidence (although focused more on that narrow question regarding the temperature of the water). He explained that he did not see the water being thrown, he just heard "*water*" – and assumed the worst-case scenario of the water being hot.[1102] He was subsequently told by DCO Albert (during the incident) that the water was cold.[1103] Pausing there, DCM Webb did state in his UoF report that D642 "*had thrown hot water over a[n] officer*".[1104] In his oral evidence, he explained why he did this – despite having already been told since that the water was in fact cold – on the basis that "*it's about my justification… I thought that was fact at the time*".[1105] Steve Webb is correct in part: it is important to record his contemporaneous understanding during the incident and when decisions are taken – precisely because they are relevant to the justification of the use of force. However, it is also important to be completely accurate, and his report was inadvertently misleading in this regard. More accurate wording would have been along the lines of: "*D642 threw water over an officer. At the time I understood that water to have been hot, but have since been informed that it was in fact cold*". In any event, as noted above, little turns on this narrow factual question. The core issue – as Mr Collier observed – was about risk, not about what temperature. DCM Webb explained his thinking in oral evidence:[1106]

> "Regardless of whether it was hot or cold, you don't throw water over an officer. Good order of the establishment. I had to remove him from the wing because that was going to escalate and I could have possibly lost the wing."

652. This answers Mr Collier's query: the water aspect was one element of D642's concerning and abusive behaviour towards staff, which DCM Webb considered to be at risk of escalating – amidst a medical emergency taking place nearby. As he candidly explained orally, "*I think that's the closest I've come to losing the wing, to be honest with you… it was very important to get him off the wing as quick as possible*".[1107] As such, there was a need to remove D642 from the situation rapidly, because of the risk of his own escalation and the potential spill-

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[1102] Steve Webb 8 March 2022 158/19-159/3

[1103] Steve Webb 8 March 2022 159/16-19

[1104] CJS005587_0017

[1105] Steve Webb 8 March 2022 160/8-16

[1106] Steve Webb 8 March 2022 161/2-7

[1107] Steve Webb 8 March 2022 155/1-14

over to other detainees who were congregating, "*everyone shouting, cheering, you know… and then people start interfering*".[1108]

653. For those reasons, the Inquiry can safely conclude that force was absolutely necessary in the circumstances of a fractious wing while staff were trying to deal simultaneously with a medical emergency and D642's disruption.

654. This is also consistent with the conclusions of the PSU, whose investigation was broader than Mr Collier's expression of expert opinion – as it goes wider than simply the use of force. In relation to those broader matters, the Inquiry is invited to accept the conclusions of the PSU in Section 7 of its report, including its observations that:

(a) Staff reports and statements were not only corroborative of each other and internally consistent, but supported by the objective CCTV footage.[1109]

(b) There was no evidence to support the allegations either that D642 had been assaulted by DCM Webb or that homophobic comments had been made to him by DCO Albert.[1110] In that regard, the Inquiry is simply not in a position to make any such findings adverse to the staff members involved – particularly so in circumstances where D642 has not provided evidence to the Inquiry and his account has not been tested. DCO Albert has also not had the opportunity to give her account directly to the Inquiry; and the Inquiry does not have any evidence corroborative of the complaint that was not available to the PSU.

655. It is, however, right to observe that the PSU did find one aspect of the complaint substantiated – that in relation to the allegation that DCO Lunn dragged D642's bag of property on the floor, causing damage to items therein.[1111] The PSU observed that CCTV footage appeared to corroborate this evidence – and G4S accepts this. DCO Lunn should not have transferred D642's bag in such a manner and it was right for the PSU to recommend that reasonable and fair reparation should be made to D642 for this.[1112] That suitably

[1108] Steve Webb 8 March 2022 155/1-14

[1109] HOM002694_0012, para 7.3

[1110] HOM002694_0012, para 7.5

[1111] HOM002694_0016, paras 7.43-7.44

[1112] HOM002694_0016, paras 7.44

addressed the complaint, alongside the further recommendations concerning DCO Lunn set out in paragraphs 8.6-8.9 of the PSU report.[1113]

Row 54: Staff response to allegation that water thrown over D668 by another detained person

656. This incident occurred on 12 August 2017 and was the subject of investigation by the PSU.[1114] It is important to note that the allegation here is not that any member of staff threw water over D668, but that this was done by another detained person; and that staff did not properly (or at all) respond to D668 raising a complaint in relation to this.

657. The Inquiry has D668's evidence on the issue – primarily in the First Annex to his witness statement.[1115] It was only addressed very briefly during D668's oral evidence.[1116] In short, D668 contends that while he was eating lunch with D450 "*in the second week of August*", another detained person dropped "*a bucket of water from the 2nd floor*" to where they were sitting. They had suspicions as to who the perpetrator was because of a trail of water and a bucket in a detained person's room. D668 states that he and D450 went to inform staff in the wing office (being Joe Bryant and two security guards) – to which they were told that they would sort the matter and come back to D668 and D450. D668 reports that he then saw one of the guards go to the second floor and speak to the man they suspected had thrown the water. When they went back to the wing office to ask about the findings of the investigation, "*the officers told me that they had seen the person but they could not tell me who it was. As far as I am aware, the detainee was not disciplined*".[1117]

658. DCM (then DCO) Ryan Harkness recalled the incident and his evidence is adds to that of D668:[1118]

    (a) He explains that the incident occurred as two individuals threw a latex glove (not a bucket) filled with water onto the suicide netting below, causing it to burst over a number of residents.

[1113] HOM002694_0017-0018

[1114] HOM002748_0028-0030

[1115] DL0000151_0011-0012, paras 70-79

[1116] D668 6 December 2021 77/13-78/20

[1117] DL0000151_0012, para 76

[1118] SER000440_0030-0031, paras 100-102

(b) He (DCM Harkness) was in the office at the time – which was during lunch. He called the two perpetrators into the office to discuss the incident and found out what had happened; both were apologetic. He left any further decision-making to a manager.

659. The PSU report records that "*some managers had become involved and spoke to the two perpetrators. They had decided to monitor the situation. The affected detainees had been told G4S were dealing with the incident*".[1119]

660. It appears, therefore, that something (likely a water-filled glove) was dropped, causing water to hit D668 and D450. In terms of the interactions between staff and D668 in relation to this incident, once the matter had been reported, D668 does record being told by staff that they had 'seen' the perpetrator[s], but that they would not divulge their identit[ies] to him. He complains, though, that he was not given assurances about his safety, or informed if the relevant person[s] were disciplined. Putting aside that staff do not have disciplinary powers in an IRC, it is submitted that what was said to D668 was sufficient: namely that the perpetrator[s] had been identified and spoken to about the matter. The only possible criticism that could be made is that staff could have gone slightly further and provided formal reassurance regarding recurrence. It is submitted that such an oversight is not significant. Indeed, the PSU accepted the rationale not to identify the perpetrators to other detained persons because of the risk of escalation:[1120]

> "He said that they could not identify the two perpetrators to the other detainees because the "detainees had been gunning for blood and he was not in the position to put the two detainees in a predicament by saying who it was. They would have been potentially targeted and I would be held responsible for that. I dealt with it professionally through the managers and the correct channels. I would never identify a perpetrator to another detainee." It might be seen that no action had been taken. He had spoken to the detainees and said that they had spoken to the perpetrators and "taken the appropriate action that we felt was necessary for the safety and maintaining the running of the centre."

Moreover, D668 himself reports having witnessed staff go and speak to those he thought responsible for the incident.

661. As such, G4S submits that staff conduct in relation to the incident vis-à-vis D668 was generally appropriate. However, it does accept – as the PSU concluded – that there were other aspects of the handling of the incident which do not accord with proper protocol and

[1119] HOM002748_0028, para 7.2.2

[1120] HOM002748_0014, para 6.3.6, accepted at HOM002748_0028, para 7.2.3

procedure. These concern matters of internal procedure and protocol. More specifically, following this complaint, there should have been (but was not) a written record made relating to what had taken place and the response to it; as well as a more formal response to D668 (rather than just what he had been told informally by DCM Harkness (quoted above).[1121]

662. G4S respectfully submits that this incident – or, more specifically, the Company's handling of it – could not have had a substantial impact on D668 in circumstances where: (a) DCM Harkness' evidence is that the water-filled glove burst over a number of detained persons (and thus was not targeted at D668);[1122] and (b) although D668 was not provided with a formal reassurance or response to his complaint, he was told that appropriate action had been taken, and had, himself, seen staff go and speak to the perpetrators. It is suggested that an additional, formal response would have had little different impact on him.

ANDREW SHARLAND QC

DANIEL ISENBERG

11KBW

3 May 2022

[1121] See HOM002748_0029-0030, paras 7.2.3-7.2.13

[1122] SER000440_0030, para 101