**IN THE BROOK HOUSE PUBLIC INQUIRY**

**INQUIRIES ACT 2005**

# WRITTEN CLOSING SUBMISSIONS ON BEHALF OF CHARLIE FRANCIS

## Introduction

1. These written submissions are advanced on behalf of Charlie Francis, who was a DCO at Brook House from 2012 and during the relevant period and who appears in the Panorama programme. He was suspended and dismissed in around 2018 as a consequence of an internal investigation following the Panorama programme.

2. Mr Francis was granted Core Participant status on 2 March 2022 and gave evidence on the following day (Day 23 – 3 March 2022). Consequently, the Inquiry has no opening submissions that have been made on his behalf. Mr Francis has taken an interest in the Inquiry and has followed hearings on the live link.

### Mr Francis' description of his working conditions

3. From around 2014, Mr Francis spent much of his time on E-Wing. He details the difficult conditions under which he was required to work at pages 9 & 10 of his Witness Statement (HOW000001_0009 – HOWE000001_0010) as follows:

i. *I think that the video clips show that many of the situations we found ourselves in were very challenging. I can see how very upset Callum was when he was recording. The work was really tough and was mentally very tiring. Every detainee had a different issue, with self-harm, with solicitors' papers, or with drugs.*

ii. *The work was constantly juggling plates, with detained people having problems and officers having to respond to a crisis with each detained person. I would go home after a 12 hour shift, and we would come back 6 hours later to do the same thing again which really took it out of me. I remember a new member of staff coming onto the wing. They asked 'how can you do this day in, and day out?'*

iii. *On the E Wing, your usual colleagues may be elsewhere (sick, in training, or assigned elsewhere etc). The staff who would be brought in to make the numbers up, may have never experienced work on that Wing. E Wing was different, it was more involved, there were R40s, detainees had to be reviewed and officers had to be aware of issues for lots of detained people.*

iv. *All the time a R40 is in the block, an officer had to be in that part of the wing. Most of the time there were not enough officers to cover that role. Usually, there would be two officers on E Wing, and one officer would have to go down to conduct those searches, or monitor, or appear at a case review. Very often I was the only officer on the wing, and it would increase the pressure I was under.*

v. *As above, it was common for Healthcare to bring an individual who was on drugs into the wing. When the drugs started to wear off, the person could become violent. As a result, there was always the threat of violence hanging in the air, because when people were coming off spice or other drugs people could be unpredictable, or violent.*

Mr Francis does not seek to excuse his conduct

4. It is important that the Inquiry notes, as stated in oral closing submissions, that Mr Francis does not seek to excuse his behaviour towards D1527 and D728 as shown in the Panorama documentary. He accepted in his evidence that he was shocked when he saw that programme and could not believe that he was seeing himself (HOW000001_0025).

5. Mr Francis was a capable and competent DCO. He had no antipathy towards those detained at Brook House and has told the Inquiry that he treated detainees as human beings. He also said in his evidence that he intervened on two occasions to save detainees who had tried to kill themselves. Those incidents are detailed in his witness statement dated 22 February 2022 at (HOW000001_0004).

6. This has been confirmed by colleagues with whom Mr Francis worker. DCM Steve Webb referred to Mr Francis when he gave evidence on Day 26 . He said:

> *Charlie was a good officer. He was a very good officer, who I relied on a lot. I am sorry that he got tied up in what I said.* (Day 26. Transcript. Page 199)

7. Owen Syred, when asked in his Verita interview (VER000252) about officers on E Wing who are macho and cliquey, said : *Yes. Most of the guys apart from one. Charlie, I knew very well -he was always very good with detainees.* (See Day 40 transcript, Page 59]

**Conduct shown on Panorama**

8. Mr Francis is shown on the Panorama programme making inappropriate remarks to D1527 on 25 April 2017 and using inappropriate language towards D1527 in the

aftermath of the Paschali choking incident D1527, an incident which Mr Francis described in his evidence as having horrified him (Day 23. Transcript at page 62).

9. Mr Francis accepts that he used the words: *are you going to continue being a tool –; are you a man or a mouse ; and we're getting bored with this now* . He says that he used these words as an attempt to bring D1527 out of his state of anxiety- to bring him back to reality / his normal state.

10. In his witness statement dated 22 February 2022, Mr Francis has commented on the video footage of the incident. He states:

> *Looking back at it now, I know that I should have picked better words to use to the detainee. I believe that I was quite calm because I had become very used to situations where people were extremely upset. I believe that I had almost become numb to the emotion of the situation. I fully accept that the things I said were offensive and were not appropriate. At the time, I was dealing with a difficult situation. Looking back, I should not have said those insensitive things.*
>
> *Having reviewed the footage preparing this statement, I am shocked and surprised at how I behaved and how I reacted to that situation. I did not want to have someone die on my shift, and that may have made me unsympathetic in the moment. When I first dealt with someone who had tried to commit suicide, it was shocking and upsetting. After a time, it became part of my every day. You cannot go home and explain to your wife or your friend what you had done that day, because they would not or could not understand what happened regularly at work. However, I regret that my behaviour was inappropriate.* (HOW000001_0011).

11. Mr Francis confirmed in his evidence that he now understands that he was unable to distinguish between a detainee who was capable of rational actions and a suicidal man who was suffering from mental illness.

12. It is important to note that Mr Francis received no training in mental health or PTSD awareness. In the absence of such training, he believed, in 2017, that he was able to distinguish between those who were genuinely intent on self-harm and those who he thought were 'attention seeking'.

13. Mr Francis' position is that had he been appropriately trained by G4S, he would have acted entirely differently towards D1527.

14. The same lack of awareness and training in relation to mental health issues applied to Mr Francis' exchanges with D728 on 6 July 2017. The video footage shows Mr Francis engaging in an argument with this detainee who had been trying to frustrate the officers by covering the observation hatch to his cell with tissue paper and had been complaining about lack of access to medication.

15. Mr Francis was heard to say to the detainee*: 'If I have to come back here again, you won't be going anywhere today. You'll be staying down here permanently. You understand?'* After they had left the room (and were outside the detainee's earshot), DCM Webb said, using derogatory language, that he wanted to punch the detainee and Mr Francis replied *'if you don't I will'*.

16. Mr Francis accepts that there is no excuse for his language. But, again, he was not able to understand that D728 was a man who had significant mental health problems. He only saw D728 as a difficult man who he believed was attention seeking and diverting attention away from other detainees with more genuine needs.

17. Mr Francis' primary problem was that he was not properly trained to deal with detainees with mental health and PTSD issues. He was simply not equipped by his employers to interact with and manage detainees who were displaying challenging behaviours, or who were in fact suffering from mental health issues.

**Toxic Culture**

18. Additionally, Mr Francis was not trained or equipped to deal with the negative macho aggressive culture that had been allowed to develop and fester at Brook House. It must be recalled that Mr Francis is a small, slightly built man of 60 years of age.

19. The Inquiry has heard a great deal of evidence about the toxic macho culture in Brook House:

20. Sarah Newland, in her Verita interview, referred to a cadre of large DCMs who are testosterone filled.

21. This culture was self-perpetuating. Callum Tulley spoke in his statement about new recruits coming in and replicating the behaviour of the abusive staff. In investigations into poor culture in policing this concept has been referred to as 'canteen culture'.

22. Dr Patterson referred to similar patterns of behaviour in his evidence at BHM000045> at page 22, 16, paragraph 97:

> *" if such misuse is sustained over time such patterns of behaviour can gradually become embedded as part of the service culture subtly passed on to new members of staff via modelling rather than explicit endorsement as simply the '... way things have always been done around here' ... The problem is not one of bad apples, it is of a rotten barrel ...*

Two categories of staff members

23. Mr Francis has stated in his evidence that there were two categories of staff members at Brook House. Some were, in his words, very *hard-nosed and uncaring types'* [HOWE000001_008]. These men, such as Yann Paschali, had *'no compassion or softness'.* [HOWE000001_009.] Mr Francis has told the Inquiry that he considered

that Paschali's personality was such that he should not have worked on E Wing. [Transcript. Day 23. Page 25]

24. The second category comprised other officers who, like Mr Francis and Owen Syred, were *more placid and more human*. [HOWE000001_008].

25. The former group of dominant individuals clearly prevailed over the latter. Mr Francis agreed in his evidence that he was one of those people who was susceptible to the actions of more dominant staff members. He was led into behaviour by other officers, but did not instigate the behaviour.

26. Nathan Ward has made the same point in his evidence. He described Mr Francis as someone who did not have bad intent, but was:

> *an example of someone who was caught up in the culture of Brook House.*

27. Revd Ward notes that in both the incidents in which Mr Francis is featured in the Panorama programme, he took inappropriate action and used inappropriate and offensive language when in the company of more dominant staff members.[1]

Culpability

28. Mr Francis accepts that he acted inappropriately and in an offensive manner towards D1527 on 25 April 2017 and D728 on 6 July 2017. However, it is important to note that Mr Francis, when giving evidence, expressly rejected any suggestion that he supported Yan Paschali in any way or that he tried to cover up Paschali's conduct. Mr Francis was unable to say why he failed to complete a 'Use of Force' report after the incident.

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1. [1] ' (For Revd Ward's evidence see quote and Mr Francis' responses to Revd Ward's assessment of him – see Mr Francis' witness statement at [HOWE000001_003 & _004]).

29. Furthermore, Mr Francis denied that his reluctance to give a written statement to police over and beyond that which he had given to G4S represented any attempt to protect Paschali from prosecution. He co-operated fully with G4S' investigation into the Paschali incident and there is no evidence that Mr Francis was ever told that Paschali might not be prosecuted unless he were to give a police statement.

30. It is respectfully submitted that (aside from the general prohibition in section 2 of the Inquiries Act 2005) there is no proper basis for the Inquiry to make any finding along the lines that Mr Francis was involved in any cover up or that he was aware that his actions might have influenced any decision by police or CPS to prosecute Paschali. These are matters of speculation and would detract from the generally accepted impression of Mr Francis as one of the more humane DCOs who worked at Brook House during the relevant period.

**Systemic Failings**

31. Mr Francis agrees with other Core Participants that the evidence produced to the Inquiry has shown that the problem at Brook House was not one of bad apples, of isolated incidents of individuals acting inappropriately, as Mr Brockington for G4S sought to suggest in his oral evidence before the Inquiry on Day 42 but, rather arose from systemic failings, as Dr Patterson has stated [BHM000045 at page 22]- *of a rotten barrel – a corrupted culture.*

32. Ultimately it was the responsibility of G4S and the Home Office to secure the welfare of detainees at the facility; not to delegate such responsibility to inadequately trained and unsupported DCOs.

33. The Inquiry is invited to find that the systems in place at Brook House failed to provide for and ensure detainee welfare.

**SIX ISSUES**

34. There are six particular issues, which arise from Mr Francis' evidence:

**ONE: Lack of mental health training**

35. Mr Francis has stated in his witness statement, that when he attended DCO refresher courses, he would say that officers needed to receive psychological training to understand and respond to what detainees were experiencing. He states that he was not alone in thinking this:

> *Often, officers on E Wing had to get involved with the healthcare and psychological issues of detained people. I recall saying that as officers, we needed to receive psychological training to understand and respond to what the detainee was experiencing. I remember that I was not alone in thinking this, and from my memory those who were on my shift thought the same thing.* [HOWE000001_0006].

36. Mr Francis accepted in his oral evidence that he was in no position to distinguish between someone who was behaving in a particular way because he could not help himself through mental illness, or somebody who was just plainly being disruptive and manipulative.

37. This is because, despite having raised the issue with G4S, Mr Francis had received no mental health training. He raised this issue when interviewed by Dominic Aitken in July 2017 [INQ000083_0008] and expanded on the issue in his witness statement :

*My view was that providing training would have helped us to know how to deal with people suffering with mental health or psychological issues. The only information I received was from the Registered Mental Nurse, or from overhearing and listening to the psychologist/psychiatrist when he came onto the Wing. I believe that it would have helped enormously if I had received basic training in psychological issues or drug abuse. It would have made dealing with vulnerable detained people more straightforward, effective. It would have also improved outcomes for the detained people._.* [HOWE000001_0024].

38. Indeed, Mr Francis may have believed that he was doing some good by speaking harshly to some detainees. He says in his witness statement:

> *By saying something that may be considered offensive or inappropriate, I would do so to snap a detainee out of an emotional or vulnerable state…* [HOWE000001_0008].

39. He told the Inquiry in his oral evidence that his inappropriate words to D1275 were an attempt to '*shake him back to reality',* that he was *'trying to help' and* that his actions were '*just my way of dealing with it.'* [Day 23. Transcript. Page 64]

40. Mr Francis' words must be viewed in the context of a person who had not been provided with any training in dealing with anxious and vulnerable detainees, who had or may have had mental health issues.

41. Other witnesses have commented on the lack of awareness of mental health by DCOs and DCMs at Brook House.

42. Dr Hard confirmed in his evidence to the Inquiry on Day 39 that staff didn't understand D1275's mental health problems. He agreed with counsel that they were not

concerned about his welfare, as such. Rather, they were frustrated by the presentation of his symptoms. [Transcript. Day 39. Page 118]

43. It is a matter of some concern that the Nurse who was in the room, who can be assumed to have been aware of mental health issues, behaved no differently.

44. Professor Bosworth dealt with the issue of inadequate training on Day 40. She said that the training given to DCOs was *pretty minimal and focused on security*. It did not enable staff to see the residents on E Wing as highly vulnerable, but rather as dangerous and difficult.

The exchange between CTI and Professor Bosworth on this issue is at pages 22 and 23 of the Day 40 transcript as follows:

> *Q. Do you think that would have made a difference, if there was a -- if DCOs, when they had part of their initial training course, were given assistance in how to deal with the nature of the population or some of the population they were expected to deal with, or not? Or do you think that's just, for the type of people who become DCOs, and their expectations of the job that they have, do you think that that just wouldn't make a difference to culture and, for example, speaking about mentally disturbed or ill people as "nutters"?*
>
> *A. I mean, I think that's a very difficult question, because I think it's clear that the training of DCOs is -- it seems to me that it's inadequate and that it's inadequate for a series of reasons, one of which is that it's fairly minimal and it's pretty much focused on security. So, yes, you know, I think having more training, more advanced training, better training, training on mental health issues, could be -- you know, could assist*

45. Professor Bosworth recommended mental health training and a focus on secondary trauma training for DCOs so that they would be able to conduct their duties with

empathy - and recognise the that dehumanisation, aggression and losing control of emotions can be symptoms of secondary trauma in detention centre staff themselves. She said:

> *A. Secondary trauma is, you know, what happens if you are confronted often with other people's trauma. So if you are an officer and you're dealing -- if you are a detainee custody officer and you are hearing a lot from the people in your care about their experiences, you know, in their -- if they're asylum seekers, for instance, or if they had PTSD or if you are dealing with a lot of distress, you are ultimately affected by that distress, and what secondary trauma counselling can do is, it can try and give officers tools for acknowledging that they are feeling distressed themselves because they are hearing about other people's distress and give them tools for recognising it and for recognising the effects of secondary trauma, because the effects of secondary trauma are things like dehumanisation, aggression, losing control of your own emotions, things like that. I think there is scope for doing more with staff, but I'm not convinced that that would eradicate the problem.* [Transcript. Day 40. Page 25]

46. Furthermore, there appears to have been no mental health element in C&R training. On Day 41 John Collier, a Use of Force expert, told he Inquiry that the test criteria used to medically evaluate the appropriateness and safety of C&R techniques employed in an IRC does not include consideration of mental illness or vulnerabilities such as histories of torture and trauma. [Transcript. Day 41. Pages 140-141] This is particularly concerning when detainees in Brook House included failed asylum seekers who may well have suffered torture and trauma in their countries of origin.

47. This is a matter of some concern, as mentally ill detainees subjected to these procedures in the relevant period are likely to have found the experience terrifying and to have been retraumatised.. The Inquiry has received evidence from Professor Katona [BHM000030, page 38] and Dr Bingham [BHM000033, page 50] to the effect that the use of physical restraint is likely to be traumatising in itself for detainees

with pre-existing clinical vulnerabilities and risks re-traumatising those with a past history of torture and trauma. [2]

48. Apparently, none of this was in the thinking of G4S or the Home Office; and it certainly did not translate into training for staff.

49. In July 2020, the Home Office introduced Detention Services Order 004 of 2020 to give guidance to ensure that necessary support is offered to those who lack decision making capacity.

50. In our submission, this guidance might have assisted Mr Francis in carrying out his duties on E Wing, but it is only guidance. It does not provide any substitute for the sort of mental health training which should have been given to DCOs.

51. Mr Francis submits that the Inquiry should recommend that all IRC staff receive mandatory Mental Health awareness training (including PTSD training) from a recognised and independent source. The Chair will recall Hindpal Singh Bhui giving evidence on Day 37 to the effect that HMIP might be able to assist with training of DCOs. [Transcript. Day 35. Page 205]

## TWO Unique situation at Brook House, for which training was inadequate.

52. Mr Francis' evidence highlighted the fact that Brook House was no ordinary detention facility. He stated in his evidence that there were DCOs who left Brook House shortly after completing their training because they realised that they had not been properly trained to deal with the conditions there. [HOWE000001_0005].

53. There were a number of problems, unique to the facility for which Mr Francis received none or inadequate training or guidance from G4S.

[2] See Day 41 transcript at page 138.

54. Firstly, there was the fundamental problem was that the detainees had no finality as to duration of their stay in detention. Some individuals believed they would be staying at Brook House for 2 weeks or 2 months, but ended up staying there for 2 years. In reality Brook House must have seemed like a place of internment to many who were there.

55. In his witness statement, Mr Francis states:

> *I was not trained to deal with the situations where asylum seekers and criminal detainees were being held in the same place, or the challenges I would face where individuals who had been detained for 2 years rather than two months.* [HOWE000001_0005].

56. These cases are not 'outliers' as Mr Riley stated in his oral evidence on Day 44. The Inquiry is referred to the oral submissions on Day 45 from Mr Lee on behalf of D643, who was detained at Brook House for 558 days.

57. Unsurprisingly, indeterminate duration of detention created levels of exasperation and desperation – and many detainees would eventually lash out, display challenging behaviours or resort to self-harm out of frustration arising from the uncertainty of their predicaments.

58. Professor Bosworth said in her evidence on Day 40 that this issue affects staff because it makes their role unclear. She said that *if you don't know how long someone is there for it is hard to motivate yourself to invest in them as a person*. She added that this factor affected staff culture and led to desensitisation as a mechanism for dealing with people who staff members were unable to help. [Transcript. Day 40. Page 39].

59. Another problem which Mr Francis highlighted in his evidence, and which featured in the Panorama programme, was the mixing of often dangerous and violent criminal deportees in cells with vulnerable asylum seekers or overstayers.

[HOWE000001_0005]. This led to intimidation and bullying of the non-criminal detainees.

60. There were also high levels of the dangerous drug "Spice" that came through the doors, largely unchecked. Mr Francis confirmed in his evidence that he received no training on substance abuse, and would dread the prospect of violence when the effects of the drug wore off.

61. In his witness statement, Mr Francis states:

> ..... *it was common for Healthcare to bring an individual who was on drugs into the wing. When the drugs started to wear off, the person could become violent. As a result, there was always the threat of violence hanging in the air, because when people were coming off spice or other drugs people could be unpredictable, or violent.* [HOWE000001_0010]

62. It is clear from Mr Francis' evidence that Brook House was dysfunctional with unique systemic problems for which no proper staff training was given to Mr Francis and other DCOs.

**THREE - Detainees not suitable for detention**

63. The third issue, which directly affected Mr Francis' working conditions and which led to the issues that were exposed by Panorama is the fact that a significant number of detainees at Brook House simply should not have been there in the first place.

64. No amount of training could have equipped Mr Francis to deal with those detainees whose experiences of past torture, or whose mental health conditions were such that they were incapable of being managed in detention.

65. Rules 34 and 35 of the Detention Centre Rules were designed to operate as safeguarding measures in administrative detention. On Day 39, Dr Hard agreed that there were a number of deficiencies in the way in which these safeguarding rules were operated at Brook House in the relevant period.

66. For example, the Inquiry heard that in only operating a nursing screen on arrival, Healthcare failed to take account of the specific needs of detainees. [Transcript. Day 39. Pages 13-14] So, DCOs like Mr Francis were charged with looking after individuals who had already been failed by Healthcare and had been allowed into the detention facility.

67. Dr Hard agreed with the view taken by Medical Justice that the arrangements at BH made it impossible to comply with Rule 34 and Rule 35. [Transcript. Day 39. Page 20]

68. As stated above, Mr Francis worked primarily on E Wing. Dr Hard stated in his evidence that segregation on E Wing was used to manage distressed behaviour including self-harm and suicidal ideation, and certainly not for the purpose of providing treatment. Dr Hard also stated that whilst on E Wing detainees were primarily being managed by detention staff with very little clinical input.

> *Q. Evidence from the healthcare professionals to the inquiry confirmed that E wing was used to manage distressed behaviour, including self-harm and suicidal ideation, and certainly not for the primary purpose of providing treatment. Was that your understanding?*
>
> *A. Yes, it seems to be done for the convenience of the staff and not for the benefit of the detained 15 person.* [Transcript. Day 39. Page 66]

69. Sandra Calver, gave evidence that some people did indeed deteriorate as a result of being on E Wing.

70. Dr Hard stated that there was no system in place for an automatic review of detention where there had been a suicide incident or deterioration in the mental state of a detainee. It is notable that there was no consideration of D1527 under the Rule 35 process in circumstances where his mental health had clearly deteriorated. The system was dysfunctional.

Unlawful detention

71. The Inquiry has also seen and heard evidence as to the frequency with which the courts have held that the Home Office's practices in relation to immigration detainees have been held to breach Article 3 ECHR. [3]

72. The Courts have also held that the Secretary of State has detained individuals unlawfully and in breach of the Adults at Risk Policy.

73. The Adults at Risk policy was published in May 2016. It is problematic because it involves an unpalatable balancing exercise between risk factors and so-called immigration factors.

74. However, there is an underlying presumption that detention will not be appropriate if a person is considered to be 'at risk' through having experienced traumatic events or where there is medical or professional or observational evidence, that an individual is suffering from a condition, such as a mental health condition, that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention.

75. Yet the AAR policy and the Detention Centre Rules were not operated by the Secretary of State in a manner consistent with the underlying presumption in the policy, because of a culture of disbelief in Healthcare at Brook House.

[3] See, for example R (on the application of D) v Secretary of State for the Home Department [2012] EWHC 2501 (Admin);[2012] A.C.D. 120

76. The Inquiry has heard evidence that during the relevant 5 month period there were with no Rule 35(2) reports (which a medical practitioner is required to complete where he or she suspects a detained person of having suicidal ideations) and only a small number of Rule 35(1) reports (cases where a detained persons' health is likely to be injuriously affected by detention) .

77. It is therefore demonstrated that Mr Francis' position is that not only was he inadequately trained to deal with detainees who were lawfully present at Brook House, but he was required through systemic failures, to deal, whilst untrained, with numerous detainees who suffered from mental health conditions which rendered them unsuitable for administrative detention.

78. The problem therefore arises from systemic failings. It is not the responsibility of DCOs that the Secretary of State continues to detain torture victims and those with mental illnesses in circumstances that are unlawful.

**FOUR Understaffing – G4S running for profit**

79. Fourthly, a contributing factor to the situation at Brook House, as shown in the Panorama documentary, was the financial motivation of the private company that was charged with running it.

80. Mr Francis was required to work in an inhumane environment where removal and security were prioritised over health and safety.

81. Revd Nathan Ward has stated in his evidence that it is unacceptable that the welfare of vulnerable asylum seekers and other immigrants should be reduced to a contractual relationship, whereby G4S was rewarded for bringing about removals, and penalised

for anything that hampered removals; with no meaningful contractual emphasis on welfare or avoiding harm.

82. Nothing underscores this point and the perversity of the situation at Brook House more than the Penalty points in Schedule G of the GS4/ Home Office contract, in which there is a fixed fine of £30,000 if a detainee escapes – but only £10,000 if a detainee dies.

83. At paragraphs 102-103 of Revd Nathan Ward's first statement, the witness states:

> *" 102. Another point that I think is significant, is that the penalty points in Schedule G fixed a fine of £30,000 for an escape, versus £10,000 if a detainee died. This just shows the relative worth of welfare over security and how the incentives/profit costs were weighted against protecting life and welfare." [DL0000141_0035]*

84. On Day 42 Mr Altman QC put a number of questions to Mr Brockintgon of G4S, which highlighted this point. The evidence before the Inquiry demonstrates that all four companies which tendered for the contract to run Brook House were motivated to cut corners to win the contract.

85. Mr Riley, the Home Office corporate witness was reluctant to accept this when giving evidence on Day 44, but the evidence is clear. There was a split between commercial and quality considerations and Home Office evidence shows that the tender delivered 35% costs savings compared to the original budget.

86. The evidence demonstrates that from the outset the focal point was on price rather than welfare. This was the ethos that G4S inherited from GSL.

87. Sarah Newland of G4S gave evidence on Day 34 and said that G4S ran Brook House as understaffed during the relevant period, in order to attain profit and that this was

evidence of G4S prioritising profit over detainee welfare. [Transcript. Day 34. Page 191]

88. On Day 35 Mr Saunders said that there: *was certainly focus on contractual delivery and meeting contractual requirements, minimising any penalties through effective contract delivery, and there was a focus on profit.* [Transcript. Day 35. Page 80]

89. He was taken to his Verita interview, where he had stated: "*Staffing vacancies generated some profits because you were saving on costs that you had already looked at."* [Transcript. Day 35. Page 165]

90. Mr Saunders told the Inquiry that he had been talking about facts and not strategy, but the inescapable facts before the Inquiry are that G4S did run the facility as understaffed. Mr Francis gave evidence in his witness statement about his working conditions on E Wing. He said:

> *" Most of the time there were not enough officers…. Usually there would be two officers on E wing, and one officer would have to go down to conduct searches, or monitor or appear at a case review. Very often I was the only officer on the wing and it would increase the pressure I was under. "* [HOWE000001_0010]

91. This state of affairs can be contrasted with the evidence of Mr Hewer who, on Day 43 told the Inquiry that on weekdays daytime there should be minimum 10 DCMs and 75 DCOs at Brook House, on Weekends daytime, 9 DCMS and 76 DCOs and overnight 2 DCMs and 18 DCOs as a minimum requirement. He added that these minimum requirements should not vary with occupancy. [Transcript. Day 43. Page 12]

92. Mr Francis told the Inquiry about having to deal with 100 people on a wing. He described the work as mentally *draining.* He referred to 12 *hour shifts with a 1 hour break.* [Transcript. Day 23. Page 19] He says in his statement that quite often officers

working on E Wing would have to work from 7.45 am until after 5pm without staff cover to enable them to take a break. [HOWE000001_0021]

93. These conditions placed DCOs under considerable stress. Mr Francis has stated that on 6 July 2017 (the same day as the incident concerning D728) there were two 'First Responses' within 20 minutes, which was an unusual and very stressful situation. [HOWE000001_0018]

94. In answer to questions from the Chair, Mr Francis said that it would have been helpful for him to have had other staff present to have taken him away from a situation where he was feeling frustrated or tired. [Transcript. Day 23. Page 89]

95. However, G4S did not provide staff support to assist when officers were struggling to cope. They had no motivation to do so; quite the reverse.

## FIVE Whistleblowing.

96. Mr Francis told the Inquiry that he was horrified, shocked and mortified at Yann Paschali's actions on 25 April 2017 [Transcript. Day 23. Page 53]. However, he told Mr Altman QC that his life would not have been easy if he had tried to report his concerns. [Transcript. Day 23. Page 52]

97. Callum Tulley told the Inquiry that there was a '*Speak Out*' poster on the wall outside some lavatories. However, it had been defaced with words such as '*Snitch*' and '*Grass*'

98. Mr Tulley gave evidence to the effect that he felt unable to complain about the abuse that he had witnesses at Brook House. Indeed, within the first two minutes of the Panorama documentary Mr Tully states,

> "*I didn't complain, I didn't think anyone would listen.*"

The evidence of Mr Syred

99. In effect, Mr Francis was powerless to report the abuses that he had seen and experienced. The evidence of Owen Syred, who gave evidence on Day 11, sums up the issue. He reported an incident of racist comments involving Sam Gurney and was subsequently the subject of intimidating behaviour, which included offensive post it notes on his locker, calling him a '*Grass*' and ' *n-word lover*' [Transcript. Day 11. Pages 116-117]

100. Professor Bosworth confirmed in her evidence that this was not an environment where people were encouraged to report their concerns. [Transcript. Day 40. Page 81]

101. Mr Syred's experiences were put to Mr Brockington of G4S on Day 42, who said that staff were trained to speak out '*when they found areas of concern, and either through line management, which would be our primary option, or by whistleblowing if they chose not to use the line management reporting process.*'

102. Mr Brockinton's evidence on this point was unconvincing, not least because, as Mr Altman QC pointed out, " *Callum Tulley was a DCO, his line managers were DCMs and he made it perfectly clear to us, when he gave evidence in the first phase of this inquiry, that the principal reason he reported none of this to other DCMs was because the DCMs were involved in it themselves.*' [Transcript. Day 42. Page 60]

103. The ineffectiveness of Whistleblowing at Brook House is demonstrated by the evidence of Callum Tulley , who told the Inquiry that he had no option other than to go to the BBC – because officers would have closed ranks – and it would have been their word against his.

104. However, there was a further systemic problem at Brook House in that complaints, when made, were not taken seriously. This is dealt with in the evidence of Stacie Dean, who complained in 2015 and states in her statement as follows:

> *" Both myself and Ms Brown were concerned that some members of staff, as well as detainees, were being regularly subjected to bullying behaviour from some staff. The response of the SMT was consistently uninterested. I do not recall specific dates or times but do remember the general approach to any of us raising concern or complaint would be fairly generic and non-committal and the lack of any action was frustrating. At times I think the view from some SMT members was that the situation was amusing, so it was far from taken seriously."* [INQ000172 at page 2]

105. The evidence demonstrates that Mr Francis' actions were the result of his being immersed (untrained and unsupported) into a culture which, through an absence of effective complaints procedures, DCOs were powerless to change.

## SIX Home Office creation of a hostile environment.

106. The final issue which is relevant to Mr Francis' evidence is the ethos of the Home Office.

107. Ben Saunders, the Centre Director, gave evidence on Day 35 and confirmed that the Home Office created a hostile environment, which was linked with discouraging people from coming to the UK in the first place. [Transcript. Day 35. Page 126]

108. He had earlier stated that the Home Office line was that the detainees at Brook House *had had opportunities to leave the UK and if they found themselves in an IRC – they had brought this on themselves* and that although some individuals may have cared, as a corporate entity, the Home Office was more interested in getting these people out of the country. [Transcript. Day 35. Page 123-125]

109. It is this approach from the Government Department that is ultimately responsible for the care of those who it detains, which substantially contributed to the dehumanisation of the detainees that has been shown on the Panorama programme.

110. The link between the Home Office ethos and dehumanisation of detainees is demonstrated through the evidence of Dr Brodie Patterson, who has provided a witness statement to the Inquiry (BHM000045), which refers to the narrative which has gained prominence since 2012 as a result of UK Government policy which has sought to create a hostile environment for immigrants. He states as follows: (emphasis added)

> *"(dehumanisation) ...is more likely to happen more where the victim is already a member of a marginalised or stigmatised group or where action is justified on the basis of the transgressions of that individual or group. As Arendt ... observed, labelling in some circumstances creates 'moral distance'. This serves to render those affected by the label less than human and thus undeserving of the natural human pity that might otherwise serve to prevent abuse.*
>
> *Unfortunately, there is little doubt that a series of narratives have served over time to distance or other asylum seekers from 'us' ...* ***Of particular significance to the context of an IRC such as Brook House is a theme in the narrative distinguishing between 'genuine' asylum seekers, ie, those seeking refuge, and bogus asylum seekers framed as only entering the country for economic benefits and deserving of sanction and punishment ... This narrative has gained prominence as a result of UK Government policy since 2012, which has sought to create a 'hostile environment'. The aim being to create a life 'so***

***unbearable for undocumented migrants that they would voluntarily choose to leave' as their access to public services becomes increasingly restricted ..."***

111. These comments of Dr Patterson were put by Mr Altman QC to Professor Bosworth on Day 40. Professor Bosworth agreed that this dehumanisation contributes to the risk of abuse. [Transcript. Day 40. Page 54]. She said :

> *"The only moral narrative about immigration removal centres is either the kind of security one, which is that these are potentially dangerous foreigners who we need to get rid of, or it's a kind of -- I mean, I think it is perhaps, you know, a moral narrative, you know, that they don't deserve to be here, that they didn't do all the right things and, therefore, we owe them nothing. "* . [Transcript. Day 40. Page 47]

112. It is submitted that this narrative, that of the Home Office's, leads to desensitisation of staff members and dehumanisation of detainees in IRCs.

113. The dehumanisation of detainees has affected their mental health needs. On Day 28 the Inquiry heard evidence from a former mental health nurse at Brook House, Karen Churcher, who stated that she thought that the Home Office did not take the mental health of detainees seriously. [Transcript. Day 28. Page 22].

114. Ms Churcher has also stated that it was the Home Office view that detainees with mental health difficulties were better off in detention rather than being released from detention:

> *"I disclosed to D1527 that the Home Office chose not to release detainees if there is a risk that they will harm themselves as detention is a safer place. I had witnessed the Home Office saying this to detainees. They said if we release*

*someone who is vulnerable then they have no support network and it puts them at risk. They are safer in detention because they have access to 20 a lot of different support."*_[Transcript. Day 28. Page 24]

115. Lee Hanford, the Centre Interim Director, gave evidence on Day 31 to the effect that the Home Office were critical of G4S staff for showing too much empathy. Like Mr Saunders he took the view that the Home Office was fixated with the removal process. [Transcript. Day 31. Pages 88-89]. On Day 44, Mr Riley, the Home Office corporate witness, eventually accepted in his evidence that the Home Office was ultimately responsible for the treatment of detainees at Brook House over the relevant period. [Transcript. Day 44. Page 180]

116. However, it is clear that the Home Office failed to comply with that responsibility and to ensure the wellbeing of detainees at Brook House over the relevant period. Professor Bosworth said in her oral evidence on Day 40 that the Home Office ought to have known what was going on at Brook House – but her understanding is that they did not concern themselves with detention.

*- I think they ought to have known, because they're the authority and Brook House was being run on their behalf. So they ought to have known in a kind of moral sense and in a legal sense. They also ought to have known because, although they are located on the administrative corridor, you would have 23 thought that they would have seen some detention officers and they would have had some inactions with them……..*

*My understanding …is that they do not concern themselves with the experience of detention, and that would be somewhere where changes could be made, actually.* [Transcript. Day 4o. Page 142 - 143]

117. We submit that Mr Francis was required to work within a toxic staff culture at Brook House. However, the entire system was dysfunctional. The Home Office were aware of and caused this dysfunctionality. We adopt the point that Mr Altman QC' put to Mr Riley on day 44: that the Home Office has for many years found the system too cumbersome to bring about any meaningful change and has simply sat on the problem.

118. These systemic failures are responsible for the culture which led to the mistreatment of detainees at Brook House.

**CONCLUSIONS**

119. The issues raised on behalf of Mr Francis engage directly with the Inquiry's Terms of Reference. In particular:

1. Whether methods, policies, practices and management arrangements (both of the Home Office and its contractors) caused or contributed to any identified mistreatment.
2. Whether any changes to these methods, policies, practices and management arrangements would help to prevent a recurrence of any identified mistreatment.
3. Whether any clinical care issues caused or contributed to any identified mistreatment.
4. Whether any changes to clinical care would help to prevent a recurrence of any identified mistreatment.
5. The adequacy of the complaints and monitoring mechanisms provided by Home Office Immigration Enforcement and external bodies (including, but not limited to, the centre's independent monitoring board and statutory role of Her Majesty's Inspectorate of Prisons) in respect of any identified mistreatment.

**Findings of Fact sought.**

120. Representatives of Core Participants have submitted that this Inquiry represents a unique opportunity to ensure meaningful change in the IRC system. This opportunity may not be presented again. It is therefore important that the Inquiry makes bold and robust findings in order to prevent the matters disclosed in the Panorama programme being the subject of a future non-statutory or statutory Inquiry in 5 years' time (as put by Mr Altman to Mr Riley on Day 44).

121. Ultimately, although Mr Francis behaved unacceptably towards D1527 and D728, he was at the centre of a perfect storm.

122. The reality of the situation faced by Mr Francis is that DCOs were unequipped to face the unusual challenges of an IRC as a result of a lack of training and support. Yet they were required to deal with mentally unwell detainees at a facility where:

- men were often detained for apparently indefinite periods.
- detention of those with mental health problems was very often unlawful;
- vulnerable asylum seekers and visa overstayers were required to share rooms with dangerous criminals;
- drugs and violence were rife; and
- segregation was used as a means of managing vulnerable detainees.

123. Furthermore, the facility was run by an organisation that prioritised profit over safe staffing levels and the welfare of detainees.

124. And, on top of all of this, Brook House was overseen by a government department that has sought to stigmatise and marginalise immigration overstayers, failed asylum

seekers and criminal deportees; and where the priority to remove competed on a daily basis with a fundamental duty to treat detainees lawfully and humanely.

125. We ask that the Inquiry makes robust findings in these terms.

126. Finally, it is submitted on behalf of Mr Francis that the evidence has demonstrated the need for the Inquiry to make the following 10 recommendations:

- That the Home Office exercises a greater degree of oversight of IRCs to ensure contractors operate in a transparent fashion.
- That contracts with IRC operators are varied or drafted to contain provisions requiring prioritisation of the welfare of detainees.
- That contracts with IRC operators are varied or drafted to contain provisions requiring mandatory staffing levels.
- That all IRC staff receive mandatory Mental Health awareness, including PTSD, training from a recognised and independent source, such as HMIP.
- That all IRC staff are provided with counselling or other facilities to manage secondary trauma and stress levels
- That, those who are unsuitable for detention are screened out at an early stage through, as Dr Hard has recommended, the Home Office engaging independent medical advisors to assess individuals prior to admission to an IRC.
- That segregation is no longer used as a means of managing those in detention with mental health problems
- That effective complaints procedures /whistleblowing policies are implemented in all IRCs with specific focus on dealing with abuse of detainees.
- That policies are brought into effect to bring about change to the culture within the Home Office in relation to immigration detainees.
- That the practice of apparently indeterminate detention is brought to an end, with detainees being informed of a fixed date when their detention will end in the event that they cannot be returned.

29 April 2022

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