

<p>1 Tuesday, 23 November 2021</p> <p>2 (10.00 am)</p> <p>3 (Proceedings delayed)</p> <p>4 (10.31 am)</p> <p>5 Welcome and opening remarks by THE CHAIR</p> <p>6 THE CHAIR: Good morning. I would like to start by</p> <p>7 sincerely apologising for the delay. I'm very sorry</p> <p>8 that you have been waiting for 30 minutes. We have had</p> <p>9 some technical issues. My apologies.</p> <p>10 My name is Kate Eves and I'm the chair of</p> <p>11 the Brook House Inquiry. On behalf of the inquiry,</p> <p>12 I formally welcome you to the first day of the inquiry's</p> <p>13 substantive hearing. This part of the hearing is</p> <p>14 scheduled to run for 14 days, until Friday, 10 December,</p> <p>15 and the second part of the hearing will commence</p> <p>16 in February 2022.</p> <p>17 This is an important day for the work of the inquiry</p> <p>18 and for core participants and witnesses. As you all</p> <p>19 know, on 4 September 2017, the BBC aired a Panorama</p> <p>20 documentary entitled "Britain's Immigration Secrets".</p> <p>21 That programme showed footage filmed covertly by an</p> <p>22 undercover reporter between April and August 2017 at</p> <p>23 Brook House Immigration Removal Centre. A number of</p> <p>24 investigations followed and, on 5 November 2019,</p> <p>25 the Home Secretary appointed me to conduct a statutory</p> <p style="text-align: center;">Page 1</p>	<p>1 reviewed over a quarter of a million pages of evidence</p> <p>2 and disclosed some 50,000 pages of relevant evidence to</p> <p>3 core participants in addition to a large volume of video</p> <p>4 footage.</p> <p>5 Core participants and their legal representatives</p> <p>6 have, of course, had to review that evidence in</p> <p>7 preparation for the hearing, and I and the rest of</p> <p>8 the team are very grateful for this work and for the</p> <p>9 ongoing work involved in preparing for the continuation</p> <p>10 of the hearing in February next year.</p> <p>11 Phase 2 will include evidence from formerly detained</p> <p>12 people, former and current G4S and Home Office staff,</p> <p>13 evidence from the three experts I have commissioned to</p> <p>14 look into culture, healthcare and use of force at</p> <p>15 Brook House, and evidence from organisations with</p> <p>16 a remit to oversee Brook House.</p> <p>17 As I have said, this statutory inquiry into events</p> <p>18 at Brook House in 2017 was announced in November 2019.</p> <p>19 The inquiry's progress has, at times, been slower than</p> <p>20 intended, partly as a result of the COVID-19 global</p> <p>21 pandemic.</p> <p>22 I am aware that many of the core participants in</p> <p>23 this inquiry, and particularly those who were formerly</p> <p>24 detained, have very much wanted to have the opportunity</p> <p>25 to have their accounts heard, and that is why today is</p> <p style="text-align: center;">Page 3</p>
<p>1 inquiry into the mistreatment at Brook House shown on</p> <p>2 the programme.</p> <p>3 The full terms of reference are, of course,</p> <p>4 available on the inquiry website, but those terms of</p> <p>5 reference, in summary, are to reach conclusions with</p> <p>6 regard to the treatment of detainees and, where there is</p> <p>7 credible evidence of mistreatment at Brook House, to</p> <p>8 identify who was responsible for that mistreatment, what</p> <p>9 caused or contributed to the mistreatment and,</p> <p>10 crucially, what changes might be needed to prevent</p> <p>11 a repeat of such events.</p> <p>12 This hearing, known as phase 1 hearing, will include</p> <p>13 opening statements from counsel to the inquiry,</p> <p>14 Mr Brian Altman QC, and the legal representatives of</p> <p>15 core participants. It will also include evidence from</p> <p>16 individuals who were formerly detained, evidence from</p> <p>17 the BBC journalist who filmed undercover at Brook House,</p> <p>18 Mr Callum Tulley, evidence from Home Office senior</p> <p>19 management in relation to setting the context of</p> <p>20 the role and purpose of immigration removal centres such</p> <p>21 as Brook House, and evidence from non-governmental</p> <p>22 organisations, referred to as NGOs.</p> <p>23 I would like to take this opportunity to acknowledge</p> <p>24 the amount of work that has taken place to prepare for</p> <p>25 today's hearing. The inquiry team have obtained and</p> <p style="text-align: center;">Page 2</p>	<p>1 such a key day for the inquiry.</p> <p>2 Before we hear from counsel, a couple of points on</p> <p>3 housekeeping, if I may: we will generally sit each day</p> <p>4 from 10.00 am to 4.00 pm, with a lunch break from around</p> <p>5 1.00 pm to 2.00 pm and a 15-minute break in the morning</p> <p>6 and afternoon.</p> <p>7 The exception to this will be Fridays, when we will</p> <p>8 sit from 9.30 am to 1.30 pm with a longer morning break</p> <p>9 of 30 minutes.</p> <p>10 The hearing transcript is recorded simultaneously on</p> <p>11 screens throughout the room and will be published at the</p> <p>12 end of each day on the inquiry website.</p> <p>13 Any directions arising from the day's hearing will</p> <p>14 also be published on the website.</p> <p>15 As you will hear in more detail from counsel, there</p> <p>16 are anonymity arrangements in place for witnesses.</p> <p>17 Cipherring and redactions have also been used in relation</p> <p>18 to the evidence in accordance with the inquiry's</p> <p>19 redaction protocol and restriction order, both of which</p> <p>20 are available on the website. If there is an</p> <p>21 inadvertent breach of a restriction order, I will ask</p> <p>22 that the simultaneous recording be stopped momentarily</p> <p>23 so that the issue can be addressed, as appropriate.</p> <p>24 I would now like to invite counsel to the inquiry,</p> <p>25 Mr Brian Altman QC, to address me. Please do go ahead,</p> <p style="text-align: center;">Page 4</p>

<p>1 Mr Altman. 2 Opening statement by MR ALTMAN 3 MR ALTMAN: Thank you, chair. Well, on Monday, 4 4 September 2017, as you have said, BBC's Panorama 5 broadcast a programme bearing the title "Undercover: 6 Britain's Immigration Secrets". The programme sought to 7 expose the mistreatment of formerly detained persons at 8 Brook House, which was, and is, an immigration removal 9 centre, or an IRC, then operated by G4S. Material 10 covertly recorded by Callum Tulley, an undercover 11 reporter for the BBC, over a three-month period from 12 19 April 2017 to 17 July 2017 showed treatment of 13 detained persons of a dehumanising and depersonalising 14 nature, including physical assaults and verbal and 15 racial abuse. Staff, including healthcare staff, were 16 involved in the misconduct. The covertly recorded 17 footage was later described by the Immigration Minister 18 as "appalling". 19 Neither Home Office staff located at Brook House nor 20 the Independent Monitoring Board, the IMB, with 21 oversight at Brook House raised concerns about the type 22 of treatment of those detained at Brook House aired on 23 Panorama. Her Majesty's Inspector of Prisons, HMIP, who 24 had oversight of the centre and who had inspected 25 Brook House in late 2016, raised no significant concerns</p> <p style="text-align: center;">Page 5</p>	<p>1 was asked to determine whether a special investigation 2 conducted by the PPO was an inquiry that was compliant 3 with article 3 of the European Convention, where it had 4 no power to compel witnesses, no obligation to hold at 5 least some hearings in public and could not allow 6 properly funded representation for D1527 and D687 during 7 the investigation. The judgment of the High Court, 8 given on 14 June 2019, led the Home Department, on 9 5 November 2019, to convert the PPO's special 10 investigation, which you had been appointed to lead 11 in March 2019, into a statutory public inquiry under 12 section 15 of the Inquiries Act 2005 and appointed you 13 the chair of this inquiry, as you have said, the 14 Brook House Inquiry. 15 And so it is today that you begin the hearings in 16 the Brook House Inquiry, which you have determined 17 should be held in two phases. As you have said, today 18 begins phase 1, with this opening statement, which will 19 be followed by the opening statements from core 20 participants. Next week, you will start hearing the 21 evidence, which will continue into a third and final 22 week of this phase, phase 1. Closing statements, 23 however, will take place at the conclusion of phase 2 of 24 these hearings, which will begin, again, as you have 25 said, in February next year, and is expected to last</p> <p style="text-align: center;">Page 7</p>
<p>1 regarding mistreatment in their report published on 2 10 March 2017. On the contrary, it concluded that 3 Brook House was "reasonably good" and making "excellent 4 progress". 5 In June 2017, two formerly detained persons at 6 Brook House, ciphered by this inquiry as D1527 and D687, 7 both core participants in the inquiry, challenged the 8 failure of the Secretary of State for the Home 9 Department to order an investigation in the High Court. 10 Initially, the Home Secretary lodged an acknowledgement 11 of service indicating an intention to contest the claim 12 on grounds that the Home Department's investigatory duty 13 under article 3 of the European Convention on Human 14 Rights had, in effect, been discharged by a number of 15 other separate enquiries conducted by different bodies 16 following the broadcasting of the Panorama programme. 17 However, during the preliminary stage of the men's 18 judicial challenge, counsel for the Home Secretary said, 19 "The Immigration Minister has said that she was appalled 20 by the Panorama footage and is determined that lessons 21 are learned and there is a change of culture". 22 In September 2018, the Home Department asked the 23 Prisons and Probation Ombudsman, the PPO, to conduct 24 a special investigation into the matters raised by the 25 programme. In light of that decision, the High Court</p> <p style="text-align: center;">Page 6</p>	<p>1 some four to five weeks. I will return in a moment to 2 explain the two phases to these inquiry hearings. May 3 I first make introductions of those who are represented 4 before you today. As you know, I am Brian Altman QC, 5 lead counsel to the inquiry. I am assisted by 6 Ms Sarah Simcock, Ms Saoirse Townshend, 7 Mr Paul Livingston, Ms Jo Moore and Ms Harriet Wakeman 8 and Mr Paul Erdunast -- the latter two will be here from 9 time to time. 10 There are 24 core participants in all, whom I shall 11 introduce shortly. They comprise 12 formerly detained 12 persons, three former employees of G4S -- Owen Syred, 13 Reverend Nathan Ward and Nathan Ring. There are two 14 non-governmental organisations, NGOs: Medical Justice 15 and the Gatwick Detainees Welfare Group, GDWG. The 16 remaining seven core participants are the BBC, the 17 Home Office, Her Majesty's Chief Inspector of Prisons, 18 the Independent Monitoring Board, G4S Care and 19 Justice Services (UK) Limited and G4S Health Services 20 (UK) Limited, as well as Practice Plus Group. 21 So, with that, let me now, please, introduce their 22 representatives, and I am doing this by groups. D1851, 23 D1527, D2077, D1914, D1538 and Reverend Nathan Ward are 24 represented by Stephanie Harrison QC, Alex Goodman, 25 Una Morris and Zainul Jafferji, as I understand it, for</p> <p style="text-align: center;">Page 8</p>

<p>1 D1851 only, all instructed by Duncan Lewis. 2 D1473, D801, D2158, D1713, D1275 and 3 Medical Justice, also related by Ms Stephanie Harrison 4 QC, but with her, for that group, Shu Shin Luh and 5 Laura Profumo, all instructed by Bhatt Murphy. 6 D687, D390 and the Gatwick Detainees Welfare Group, 7 represented by Mr Nick Armstrong, Jesse Nicholls and 8 Una Morris, instructed by Deighton Pierce Glynn. 9 Owen Syred is represented by Brian Stanton and 10 Deirdre Domingo, solicitors of Innovo Law. 11 The Home Office, represented by Julian Blake, Emily 12 Wilsdon and Rebecca Handcock, instructed by the 13 Government Legal Department. 14 The BBC is represented by Jude Bunting, and with him 15 Stephanie Davan, instructed in-house by the BBC. 16 Her Majesty's Inspector of Prisons is represented by 17 Amy Mannion and Jonathan Metzger, instructed by the 18 Government Legal Department. 19 G4S Care and Justice and G4S Health Services 20 represented by Mr Andrew Sharland QC, and with him 21 Daniel Isenberg, instructed by G4S in-house and I think 22 together with DWF Solicitors. 23 The Independent Monitoring Board is represented by 24 Jonathan Dixey and Jennifer Wright, instructed by the 25 Government Legal Department.</p> <p style="text-align: center;">Page 9</p>	<p>1 there, what he experienced while employed at 2 Brook House, how and why he took his concerns to the BBC 3 and how he went about filming inside the institution 4 that led to the Panorama programme. We will also be 5 showing him a selection of the key footage in the course 6 of the evidence, and we will be seeking his assistance 7 with the context of those incidents he filmed. 8 Thereafter, we will hear live evidence from three 9 formerly detained persons and their particular 10 experiences of their treatment in Brook House. They are 11 ciphered as D1618, D668 and D1851. We also intend to 12 read or summarise the accounts of a number of other 13 formerly detained men. Others' accounts will be heard 14 in phase 2. Towards the end of the phase 2 hearings, 15 the inquiry shall also be receiving evidence from 16 Reverend Ward and Owen Syred, as I have already said, 17 former members of staff at Brook House; from 18 Dr Dominic Aitken, an academic who spent time inside 19 Brook House in the summer of 2017 doing research; and 20 from Anna Pincus, James Wilson and Jamie Macpherson of 21 the Gatwick Detainees Welfare Group; as well as Anton 22 Bole of Forward Trust and Sile Reynolds from Freedom 23 from Torture. 24 This is the opening statement for phase 1 of 25 the hearings and so it deals with the evidence the</p> <p style="text-align: center;">Page 11</p>
<p>1 Nathan Ring, we understand, is represented by 2 Ben Harrison of Milners Solicitors. 3 Finally, Practice Plus Group is represented by 4 Cecily White, instructed by Hill Dickinson. 5 So that is the representation. Let me come on to 6 the two phases of these inquiry hearings. 7 As I have said, the inquiry is conducting these 8 hearings in two parts, or phases. In the first phase, 9 beginning today, you will be hearing from witnesses from 10 a Home Office witness to set the scene for Brook House, 11 against which the evidence that follows may be better 12 understood. That will include evidence about the 13 contractual arrangements between G4S and the Home Office 14 Brook House's infrastructure, and generally how it 15 operated, just to set the scene against which everything 16 else can be understood. 17 The scene having been set, we will be hearing from 18 Callum Tulley, the BBC undercover journalist who worked 19 at Brook House as an assistant detention custody officer 20 to begin with, an ACO, and then as a detention custody 21 officer, a DCO, during the relevant period, and that's 22 a term that we will come back to again and again, and 23 the relevant period, for the purposes of this inquiry, 24 is from 1 April 2017 to the end of August, 31 August of 25 that year. Callum Tulley will tell us about his work</p> <p style="text-align: center;">Page 10</p>	<p>1 inquiry will hear in phase 1. Phase 2 will begin with 2 a further opening statement at which we will deal with 3 the evidence the inquiry is to hear in that part of 4 the hearings. In phase 2, Callum Tulley will be 5 recalled to give further live evidence about matters not 6 already covered in his evidence in the phase 1 hearing. 7 It will also include seeking his response to any 8 criticism of him by former staff members of G4S featured 9 in the Panorama programme and, indeed, others. 10 In phase 2, you will also hear live evidence from 11 staff members or former staff members of G4S. They will 12 include senior management witnesses and those who worked 13 on the ground in Brook House during the relevant period, 14 some of whom appeared in the BBC footage broadcast in 15 the Panorama programme, including those accused of 16 the mistreatment of formerly detained persons, as well 17 as others. Similarly, you will hear live evidence from 18 the management and members of the healthcare staff at 19 Brook House, including GPs and nurses, in relation to 20 the provision of healthcare in Brook House, the 21 management of vulnerable detained persons, those 22 presenting a risk of self-harm or suicide, and those 23 with substance misuse issues. There will be evidence on 24 how the process under rule 35 of the Detention Centre 25 Rules 2001 operated; that is to say, the provision of</p> <p style="text-align: center;">Page 12</p>

<p>1 a report by a medical practitioner to the centre manager 2 where it is likely that the detained person's health 3 would be injuriously affected by continued detention, or 4 where the medical practitioner suspects that a detained 5 person has suicidal ideation, or where there is 6 a concern that a detained person may have been a victim 7 of torture, and the challenges for medical practitioners 8 in those circumstances.</p> <p>9 You will also hear in phase 2 from a witness from 10 Medical Justice, a charity which provided medico-legal 11 reports and advice to detained persons.</p> <p>12 There will be evidence from senior Home Office 13 officials, who will give evidence concerning their roles 14 and their responsibilities in relation to Brook House 15 and issues such as contractual arrangements with G4S, 16 staffing levels, the system for investigation of 17 complaints and any action taken as a result of 18 the Panorama programme. Witnesses from organisations 19 responsible for the oversight and monitoring of 20 Brook House, such as the IMB, Her Majesty's Inspectorate 21 of Prisons, the National Preventative Mechanism, the 22 NPM, and the Home Office Professional Standards Unit, 23 the PSU, will also be here to give live evidence.</p> <p>24 The phase 2 hearings will also comprise corporate 25 evidence, both from G4S Health Services and G4S Care and</p> <p style="text-align: center;">Page 13</p>	<p>1 significant use of force incidents not covered in the 2 BBC footage; alleged assaults of detained persons by 3 staff; significant suicide attempts or self-harm not 4 covered in the BBC footage; significant incidents 5 relating to substance misuse not covered in the footage; 6 verbal abuse, such as racist comments between staff 7 members; incidents leading to disciplinary action 8 against staff members; and incidents which led to 9 complaints and consequent investigations by the PSU.</p> <p>10 The inquiry will also be investigating the adequacy 11 or appropriateness of healthcare provision, with the 12 assistance of Dr Hard.</p> <p>13 Let me deal now, please, with the inquiry's terms of 14 reference and its scope. The inquiry's terms of 15 reference, as you have said, chair, the full terms of 16 which may be found on the inquiry's website, are to 17 "reach conclusions with regard to the treatment of 18 detainees where there is credible evidence of 19 mistreatment" at Brook House during what I have already 20 described as the relevant period, 1 April to 21 31 August 2017, to identify who was responsible for that 22 mistreatment, what caused or contributed to that 23 mistreatment and, crucially, what changes might be 24 needed to prevent a repeat of them. The term 25 "mistreatment" refers to treatment that is contrary to</p> <p style="text-align: center;">Page 15</p>
<p>1 Justice, as well as from Serco, who now run Brook House, 2 and Practice Plus Group, a core participant who now run 3 healthcare services at Brook House, about current 4 practice there, in order to inform any recommendations 5 you wish to consider making in your report. Finally, 6 there will also be live evidence from the experts that 7 you have commissioned -- Dr Hard on healthcare issues at 8 Brook House; Professor Bosworth on the cultural issues 9 at Brook House; and from Jonathan Collier on issues 10 regarding the use of force at Brook House.</p> <p>11 In the course of these hearings, we are going to be 12 using as a guide what we call a schedule of incidents, 13 which has been created by counsel to the inquiry and 14 disclosed to core participants. It incorporates a total 15 of around 50 key or significant incidents which we will 16 be focusing on in the course of these hearings, albeit, 17 chair, it is, of course, open to you to take account of 18 the whole of the evidence received by you in these 19 hearings in order to consider the big picture of 20 the experiences of detained persons at Brook House when 21 formulating your report in due course.</p> <p>22 The schedule is designed to be a living document, so 23 it can be updated and revised as necessary as we go 24 along. In substance, it includes: the eight incidents 25 identified in the BBC footage, the key incidents; other</p> <p style="text-align: center;">Page 14</p>	<p>1 article 3 of the European Convention, that is to say, 2 torture or inhuman or degrading treatment or punishment.</p> <p>3 In your opening statement of 21 April of last year, 4 2020, you made a number of important observations about 5 detention that bear repetition now. You said that it is 6 hard for many people to understand how it feels to be 7 held in detention. Let me quote you. You said:</p> <p>8 "It is hard to imagine the experience of being 9 separated from our family, our homes and communities. 10 The effects can be profoundly humiliating and traumatic. 11 If you have significant uncertainty about what is going 12 to happen to you and your family, your vulnerability may 13 be even greater. Language barriers can cause 14 difficulties communicating with other detainees and 15 staff and you may be experiencing significant mental 16 health issues. You may not understand the legal 17 processes that you are subject to, and you may greatly 18 fear the outcome of those proceedings."</p> <p>19 As you put it, from your own experience of working 20 with adults and children detained in a variety of 21 situations and locations around the world, "inherent 22 vulnerability goes hand in hand with the experience of 23 detention". You added, "The public expects the 24 Home Office to provide a safe, decent and humane 25 environment for anyone who it or its contractors hold in</p> <p style="text-align: center;">Page 16</p>

<p>1 immigration detention. The treatment revealed in the 2 Panorama documentary was shocking and has no place in 3 a decent and humane immigration detention system. It is 4 this inquiry's role to examine what took place at 5 Brook House and how treatment of the nature experienced 6 was able to happen. Specifically, the inquiry will 7 examine whether the treatment experienced in Brook House 8 was contrary to article 3 of the European Convention on 9 Human Rights and, therefore, amounted to inhuman or 10 degrading treatment or punishment."</p> <p>11 In your opening statement, and repeated in your 12 determination on the scope of the inquiry dated 13 6 January of this year, you identified five central 14 questions that require addressing by the inquiry.</p> <p>15 First, the extent and severity of the mistreatment 16 at Brook House during the material time and to examine 17 who perpetrated it.</p> <p>18 Second, the extent to which policies, practices, 19 staffing and management arrangements at Brook House 20 caused or contributed to any identified mistreatment. 21 This question requires an examination, you said, of 22 a series of issues, which you set out in your 23 determination on scope. There are several of them: 24 direct management and leadership at Brook House; staff 25 and management training, induction and support; staffing</p> <p style="text-align: center;">Page 17</p>	<p>1 framework for identifying and responding to 2 mistreatment; the IMB's monitoring of Brook House; 3 HMIP's inspection of Brook House; informal mechanisms 4 for raising concerns, including the role of 5 the chaplaincy; and whistleblowing procedures and 6 protections for staff.</p> <p>7 The fourth central question: what changes have been 8 made in response to the Panorama documentary? 9 And, fifth, whether those changes are adequate or 10 need to be improved upon.</p> <p>11 The terms of reference for this inquiry are such 12 that the inquiry's focus is on the treatment of those 13 detained in Brook House during the relevant period. 14 What the inquiry is not tasked with or able to 15 investigate is this country's system of immigration 16 detention more widely.</p> <p>17 Now let me say a few things, please, about previous 18 investigations and reviews. Several investigations 19 arising from the events exposed by the BBC's Panorama 20 programme have already taken place and reported. I am 21 going to return to the details of two of them towards 22 the end of this opening statement. But let me just set 23 them out in summary.</p> <p>24 On 21 November 2017, two months after the programme 25 was screened, Stephen Shaw was asked by the Home Office</p> <p style="text-align: center;">Page 19</p>
<p>1 levels; prevalence of racist attitudes/behaviours and 2 measures for addressing such attitudes/behaviours; staff 3 and management culture; the co-location of time served 4 foreign national offenders, or TSFNOs, and asylum 5 seekers; the assessment of vulnerability, including the 6 process referred to as rule 35 and the Adults at Risk 7 policy; the extent and suitability of the specialist 8 mental health provision; the use of control and 9 restraint techniques, including pain compliance; the 10 availability of other methods for encouraging good order 11 and discipline and dealing with non-compliance; the 12 control of drug availability and use; response to 13 bullying or intimidation of detainees; the use of 14 segregation; management of self-harm and food refusal; 15 language barriers and the use of interpreters; and 16 management of healthcare staff.</p> <p>17 The third of the five central questions is the 18 adequacy of the safeguards designed to detect 19 mistreatment. You said this means examining a series of 20 issues, which are: the procedures for formerly detained 21 persons to make complaints and the responses to any such 22 complaints; the recording and monitoring of the use of 23 force; Home Office monitoring and oversight of 24 Brook House, including the role of the Professional 25 Standards Unit, the PSU; the adequacy of the contractual</p> <p style="text-align: center;">Page 18</p>	<p>1 to extend the scope of his follow-up review on the 2 welfare in detention of vulnerable persons, which had 3 been previously commissioned.</p> <p>4 Second, also that same month, G4S commissioned 5 Verita to carry out an investigation by Kate Lampard and 6 Ed Marsden into the issues raised by the programme. The 7 report was published in redacted form in November 2018 8 and is referred to as the Lampard Report.</p> <p>9 Third, the Home Office PSU began an internal 10 investigation which reported in February 2018.</p> <p>11 Fourth, the Home Affairs Select Committee, HASC, 12 published a report on 21 March 2019, having enquired 13 into immigration detention with particular focus on the 14 management of vulnerable individuals.</p> <p>15 Fifth, and finally, there was the National Audit 16 Office, the NAO, report published in July 2019, which 17 reported on the design of the contract between the 18 Home Office and G4S, its operation and Home Office 19 oversight.</p> <p>20 As you said in your determination on the scope of 21 the inquiry of 6 January of this year, the inquiry needs 22 to build on the findings of other relevant reviews and 23 investigations and will not seek to duplicate the work 24 of others unless evidence received by the inquiry 25 requires you to revisit the work or conclusions of other</p> <p style="text-align: center;">Page 20</p>

<p>1 investigations.</p> <p>2 Let me please come to what is really at the heart of</p> <p>3 this inquiry, and that which underlies its</p> <p>4 establishment, and that's the BBC footage, some of which</p> <p>5 aired in the Panorama programme in September 2017. Of</p> <p>6 the 109 hours of footage recorded inside Brook House by</p> <p>7 the BBC's undercover reporter, Callum Tulley, the</p> <p>8 inquiry has received and reviewed over 90 hours of</p> <p>9 recordings, of which about four hours has been</p> <p>10 identified as what we call key relevant footage.</p> <p>11 Disclosure has been made to core participants of</p> <p>12 the four hours or so of video footage. Other footage</p> <p>13 has been disclosed following specific requests made to</p> <p>14 the inquiry by core participants. The remainder of</p> <p>15 the relevant footage has been disclosed only by the</p> <p>16 disclosure of transcripts where the inquiry was</p> <p>17 satisfied that the content of the footage was relevant,</p> <p>18 but that seeing the footage itself did not add anything</p> <p>19 to the evidence, for example, where there was</p> <p>20 a conversation between staff members.</p> <p>21 Callum Tulley also made video diaries at the end of</p> <p>22 a shift, and he did so on 36 occasions, summarising the</p> <p>23 shift he had been on and any notable events.</p> <p>24 Transcripts of those video diaries have been made and</p> <p>25 they have also been disclosed to core participants,</p> <p style="text-align: center;">Page 21</p>	<p>1 to demonstrate visually the effect of an incident of</p> <p>2 mistreatment on a detained person -- that will be</p> <p>3 achieved by inviting you to go into closed session,</p> <p>4 where the footage can be shown, if necessary, questions</p> <p>5 may be asked and, on our return into open session,</p> <p>6 a summary of what took place can be provided and the</p> <p>7 examination of the witness can then continue.</p> <p>8 In relation to staff members and former staff</p> <p>9 members of G4S, the Home Office and others, such as</p> <p>10 individuals working for inspectorates, NGOs and the BBC,</p> <p>11 the approach of the inquiry has been not to redact their</p> <p>12 names in disclosed documents unless the inquiry</p> <p>13 considers that their involvement was wholly irrelevant.</p> <p>14 The inquiry's starting point has been, and remains, that</p> <p>15 the identities of those individuals are relevant; not</p> <p>16 least, it is the conduct of many of them, as well as the</p> <p>17 organisations for which they worked, which is the</p> <p>18 subject matter and focus of this inquiry and requires</p> <p>19 the greatest public scrutiny.</p> <p>20 Let me say something about witness evidence. The</p> <p>21 inquiry has received witness statements from formerly</p> <p>22 detained persons. Some are giving evidence in this</p> <p>23 phase, phase 1, while others will be asked to do so in</p> <p>24 phase 2. Inevitably, some formerly detained persons</p> <p>25 have been untraceable. Some of those who have been</p> <p style="text-align: center;">Page 23</p>
<p>1 except in one instance where the video diary itself has</p> <p>2 been disclosed in addition to the transcript. CCTV and</p> <p>3 body-worn camera footage of incidents inside Brook House</p> <p>4 has also been disclosed.</p> <p>5 Sections of the key footage will be shown in the</p> <p>6 course of the hearings. However, except where</p> <p>7 a formerly detained person has specifically requested</p> <p>8 otherwise, their faces will be blurred or pixelated out</p> <p>9 in the footage. Even then, where a formerly detained</p> <p>10 person has requested that his face be shown in open</p> <p>11 hearings, his identity will nonetheless remain</p> <p>12 anonymised in subtitling by the use of ciphering,</p> <p>13 consistent with the inquiry's protocol for the redaction</p> <p>14 of documents, your determination, chair, on the</p> <p>15 inquiry's approach to the use, publication and reporting</p> <p>16 of BBC footage dated 13 October of this year, and the</p> <p>17 restriction order made by you yesterday, 22 November,</p> <p>18 and his name will remain edited from the audio track.</p> <p>19 In all other cases, the faces of formerly detained</p> <p>20 persons will be blurred or pixelated out in the footage</p> <p>21 and their identity anonymised in the ways I have</p> <p>22 indicated.</p> <p>23 Where, however, during the course of the hearing it</p> <p>24 is necessary to put to a witness the wholly unedited</p> <p>25 version of a piece of footage -- for instance, in order</p> <p style="text-align: center;">Page 22</p>	<p>1 traced are vulnerable and are simply unable or unwilling</p> <p>2 to give live evidence or to provide evidence in any</p> <p>3 other way. In the case of formerly detained persons who</p> <p>4 have given statements to the inquiry but are unable to</p> <p>5 give live evidence, the inquiry will adduce their</p> <p>6 account by reading or summarising their statements and</p> <p>7 any previous accounts given to other tribunals or</p> <p>8 investigations. In the cases of those who have provided</p> <p>9 no inquiry statement, the inquiry will adduce any</p> <p>10 previous accounts given to other tribunals or</p> <p>11 investigations as well as the relevant content of</p> <p>12 medical reports provided for other purposes, and that's</p> <p>13 in order to provide a breadth of experience of those who</p> <p>14 were detained in Brook House during the relevant period.</p> <p>15 There has been reasonable engagement by staff and</p> <p>16 former staff members of Brook House. The inquiry is</p> <p>17 continuing to send out rule 9 requests, that is to say,</p> <p>18 requests for witness statements, with a view to the</p> <p>19 evidence in phase 2 of the inquiry. While some have</p> <p>20 responded to formal requests for statements or have</p> <p>21 returned pro forma questionnaires, many have not. This,</p> <p>22 despite the Attorney General issuing an undertaking</p> <p>23 in January of this year that, in the case of any person</p> <p>24 who provides oral or written evidence to the inquiry,</p> <p>25 that evidence will not be used in evidence against that</p> <p style="text-align: center;">Page 24</p>

6 (Pages 21 to 24)

<p>1 person in any criminal investigation or proceedings 2 unless it relates to that person's prosecution for 3 giving false evidence or for an offence under section 35 4 of the 2005 Inquiries Act. Others have informed the 5 inquiry about vulnerabilities which they say render them 6 medically incapable of assisting.</p> <p>7 The result of the non-engagement by some staff or 8 former staff members at Brook House has been for you to 9 invoke your compulsory powers under section 21 of 10 the 2005 Act in order to compel the provision of 11 evidence to the inquiry. After all, one of the features 12 which led the High Court in 2019 to determine that the 13 PPO's special investigation was not article 3 compliant 14 was the absence of any power to compel witnesses. It 15 may be, chair, that you will consider it necessary to 16 issue further section 21 notices in due course.</p> <p>17 For the sake of completeness, in addition to the 18 undertaking given by the Attorney General, of which 19 I have just made mention, in July of this year, the 20 Immigration Minister issued an undertaking at your 21 request that, where any current or former immigration 22 detained person provides evidence to the inquiry, the 23 Secretary of State may not use the evidence against him 24 in the course of any immigration proceedings; in any 25 immigration decision made by the Secretary of State; in</p> <p style="text-align: center;">Page 25</p>	<p>1 publication of the identity of those formerly detained 2 persons who had not requested it. In the event of an 3 accidental or deliberate revelation of identity in the 4 course of open hearing sessions, we will ask for the 5 live stream to be stopped so that the broadcast can be 6 edited to remove the evidence which would breach the 7 restriction order. The transcript of the proceedings 8 will also be redacted to remove the identity of that 9 person, if necessary.</p> <p>10 Most of the evidence in these hearings will be heard 11 in open session, that is to say, hearings in which the 12 public can see and hear the evidence in person or 13 online. Where, for the reasons I have already given, 14 evidence has to be heard in closed session, because, as 15 I have explained, we have to show a witness unedited 16 footage, the public will not be admitted into the 17 hearing room and the evidence will not be live streamed. 18 But everyone else -- core participants, their legal 19 teams and accredited members of the press who are 20 present -- will be able to see and hear their evidence 21 in the hearing room, but there will be no live stream of 22 that part of the evidence.</p> <p>23 Can I add, finally, at this juncture, that the 24 terminology used in this environment has evolved and is 25 changing, and we shall all do our best to use the right</p> <p style="text-align: center;">Page 27</p>
<p>1 any decision to detain or to seek to impose conditions 2 in respect of immigration bail; or for the purpose of 3 investigating any immigration matter or deciding whether 4 to bring immigration proceedings, in particular, unless 5 the former detained person has chosen to rely on the 6 evidence and it is necessary for the Secretary of State 7 to correct a false impression or assertion made by the 8 evidence given.</p> <p>9 Let me now come on, please, to say something about 10 the processes and procedures that will be adopted. To 11 assist everyone's understanding, the evidence will be 12 presented essentially in one of two ways. Witnesses 13 will either be called live, and their evidence live 14 streamed online, albeit with a three-minute delay, or, 15 if not called live, as I have already indicated, 16 witnesses' evidence will, at appropriate points, be read 17 or summarised by counsel and formally adduced into 18 evidence by such means. Documents, or parts of them, 19 that are referred to will be published on the inquiry's 20 website and video footage that is shown during open 21 hearings will be made available.</p> <p>22 Because you, chair, determined on 13 October that 23 footage shown in open session would not depict the faces 24 of formerly detained persons, as I have already said, 25 yesterday you made a restriction order to restrict the</p> <p style="text-align: center;">Page 26</p>	<p>1 terminology throughout, but the documentation to which 2 we shall be referring from time to time has not always 3 caught up and uses language no longer thought 4 appropriate. While I am on the subject of language, 5 occasionally, in the course of this opening statement, 6 I am going to resort to using only the last names of 7 persons. If and when I do so, it is not done out of any 8 discourtesy, but only for reasons of economy, and I can 9 assure those concerned that no offence is intended.</p> <p>10 Chair, that ends, as you know, the first section of 11 my four-part opening statement, which gives everybody 12 else an indication of what's to come. I'm not going to 13 promise they are all of the same length, though. We are 14 slightly early, but perhaps that would be a good moment 15 for you to rise for our mid-morning break.</p> <p>16 THE CHAIR: Thank you very much. 17 (11.20 am)</p> <p>18 (A short break)</p> <p>19 (11.44 am)</p> <p>20 MR ALTMAN: Let me deal, then, with general matters of 21 background. Brook House is a purpose-built immigration 22 removal centre located on the southern perimeter of 23 London's Gatwick Airport. It opened in March 2009. 24 While always intended to be an immigration removal 25 centre, it was built to the security specifications of</p> <p style="text-align: center;">Page 28</p>

<p>1 a category B prison. Nearby, and also on the airport 2 site, is an older and smaller facility, Tinsley House. 3 Together, they are known as the Gatwick Immigration 4 Removal Centres.</p> <p>5 Brook House is now managed and run by Serco, and, as 6 I have said, Practice Plus Group now runs its healthcare 7 services. It was initially managed from opening by G4S 8 under a contract which was between the Home Office and 9 a company known as GSL Limited. GSL Limited was bought 10 by G4S before Brook House opened and G4S assumed its 11 contractual obligations. The contract was then extended 12 in 2018. In September 2019, G4S announced that it would 13 no longer be operating at the Gatwick centres, and, 14 in February 2020, Serco was awarded the contract to 15 manage both Brook House and Tinsley House. Serco took 16 over the management of Brook House in May 2020 under 17 a contract which runs until at least 2028.</p> <p>18 The initial contract term under which G4S ran 19 Brook House was eight years. In 2016, an extension of 20 15 months was granted from February 2017 to May 2018. 21 The contract was then due to expire in May 2018 and was 22 put out to tender in January 2017. From then 23 until March of that year, 2017, G4S senior managers 24 worked on a rebid for the new contract. The Home Office 25 announced in May 2018 that G4S's contract would be</p> <p style="text-align: center;">Page 29</p>	<p>1 under headings, including: maintenance of security and 2 safety; healthcare; catering; and welfare and regime. 3 Schedule G, which was titled "Performance evaluation" 4 set out a service points value to be awarded for service 5 failings to meet any of these operational requirements. 6 Each month these would be converted into a financial 7 penalty which would be subtracted from the monthly 8 payment to G4S. The amount of the penalty would depend 9 on the nature of the failure. Some failings were just 10 so significant that they carried a flat "service credit 11 penalty". So, escape from Brook House would lead to 12 a service credit penalty of £30,000 per incident, 13 whereas self-harm resulting in death, defined as 14 self-harm of a detained person resulting in their death, 15 involving any failure by G4S to follow procedures for 16 the safety of detained persons, attracted a penalty of 17 £10,000 per incident. However, self-harm resulting in 18 injury, as opposed to death, resulting in injury, 19 defined as self-harm by a detained person requiring any 20 form of healthcare and involving any failure by G4S to 21 follow procedures for the safety of detained persons, 22 attracted a penalty of £716 per incident, together with 23 400 service points.</p> <p>24 Significant performance failings, including escape 25 and self-harm resulting in death, resulted in fixed</p> <p style="text-align: center;">Page 31</p>
<p>1 extended for a further two years, despite Panorama 2 having been broadcast some eight months earlier.</p> <p>3 The Home Office contract required G4S to manage, 4 staff and maintain Brook House. In return for this 5 service, the Home Office paid G4S fixed monthly fees, 6 which were subject to performance-related deductions. 7 The monthly fee paid by the Home Office rose with 8 inflation from 2009 when it was set, and during the 9 relevant period was around £1 million per month.</p> <p>10 G4S subcontracted some of its services to other 11 companies. During the relevant period, Aramark 12 contracted with G4S to provide catering, a shop for the 13 detained men and cleaning services. Healthcare at 14 Brook House was provided by G4S Health Services, 15 pursuant to a separate contract with NHS England.</p> <p>16 G4S also provided training to Brook House staff. 17 The content of the training was approved by the 18 Home Office. However, no penalties attached to any 19 failure to provide that training, nor was the quality of 20 the training stipulated in the contract, although the 21 nature of the mandatory training was.</p> <p>22 The contract between the Home Office and G4S 23 consisted of several schedules. Schedule D, in 24 particular, titled "Operational specifications", set out 25 the various requirements which G4S was required to meet</p> <p style="text-align: center;">Page 30</p>	<p>1 financial penalties and was not capable of being 2 mitigated. Other failures to meet agreed performance 3 standards, of which self-harm resulting in injury where 4 there was a G4S failure, was one, among many others, 5 gave rise to a penalty point deduction. The deduction 6 depended on the seriousness of the failing. If there 7 was mitigation for the failing, which was accepted by 8 the Home Office, no penalty was imposed. By 2017, 9 performance was primarily assessed on delivery against 10 25 key performance indicators.</p> <p>11 According to Ben Saunders, Brook House's then 12 director, during the relevant period, G4S's focus was 13 very much on contractual delivery. He felt the focus 14 was on targets and profit. He noted that the contracts 15 had a set profit margin, but there was an expectation 16 that he would deliver more. Money saved, he said, was 17 not for reinvestment in Brook House:</p> <p>18 "Staffing vacancies generated some profits because 19 you were saving on costs that you had already looked 20 at."</p> <p>21 That is what he had to say.</p> <p>22 Now let me deal with the physical environment at 23 Brook House. I am now going to ask the evidence 24 handler, please, to put up on screen, first of all, 25 a plan, <CJS004587>.</p> <p style="text-align: center;">Page 32</p>

<p>1 This is a plan of the ground floor. We have the 2 ground floor up on screen. If we can flick up or down, 3 as the case may be, to the next page -- probably down, 4 page 2, the first floor, and again to the next, the 5 second floor -- can we go back to the ground, on page 1. 6 This is a representative plan. It is not a plan 7 drawer's plan. It is not drawn to scale. And I'm 8 afraid it is the best that we have. As has been pointed 9 out, and is perfectly clear, although we can see in the 10 four corners of the plan, as we look down on it, we have 11 four wings, which I will come to describe in a minute, 12 shaded in blue, we also have, shaded in green, 13 courtyards, and of course, if we go to the next page, 14 page 2, the way that the plan has been drawn rather 15 looks as if the floors above cover over the courtyard, 16 and that clearly isn't the case. But, as I say, it is 17 the best that we have been able to muster, despite the 18 inquiry's best efforts to get something calling itself 19 a decent plan from anyone.</p> <p>20 I'm not going to go through all of the labelling on 21 the plans. Everybody has, I hope, seen it and been able 22 to study it and identify, insofar as they are able, 23 where the various areas on each of the floors were -- 24 offices and the like, and so on -- but what I will 25 perhaps put up and ask to keep up for the moment -- and</p> <p style="text-align: center;">Page 33</p>	<p>1 official vehicles, and something called the "sat desk", 2 where people visiting their detained friends or 3 relatives enter, are searched and escorted to the visit 4 hall, which is in the main building. The first building 5 also contains training rooms and the control room, and 6 from the control room, all parts of the centre are 7 monitored by CCTV. Detention custody officers, and we 8 will get used to the acronym, DCOs, working in the 9 control room also operate almost all electronic doors 10 within the centre and they make radio announcements for 11 staff on site. Next to this is a small second building, 12 which is a visit centre, where visitors are checked in 13 before being taken to the sat desk.</p> <p>14 The third, and main, building has three storeys, and 15 so that's the building we are looking at in the centre 16 of the image. It contains the residential part of 17 the centre. From above, it looks like a capital H 18 shape. When entering the residential block of 19 Brook House, you first come across a reception centre, 20 where detained persons are admitted to and discharged 21 from it.</p> <p>22 For residential use, Brook House is divided into 23 five wings, and they have various titles -- Arun, Beck, 24 Clyde, Dove and Eden; sometimes Alpha, Bravo, Charlie, 25 Delta and Echo, or just plain old A, B, C, D and E</p> <p style="text-align: center;">Page 35</p>
<p>1 I don't know if it can be done side by side, but 2 certainly one of the following. Can we put up for the 3 moment some images, <INQ000062>, please. Take down the 4 plan and put up the image. I don't know if we are able 5 to put up images side by side or just one at a time on 6 the screen. If we can, the next one is <INQ000063>. 7 I suspect this is going to be more helpful than what we 8 were just looking at. I will just wait for a moment to 9 see if the technicians can put them up side by side. If 10 that is not possible, I will just carry on.</p> <p>11 Brook House was built with an operational capacity 12 of 448 people -- let's leave this one up on screen, 13 please -- detained under immigration powers. When 14 constructed, it was the largest facility of its kind in 15 the UK. Its capacity was expanded in May 2017 in order 16 to house 508 people. The centre comprises three 17 buildings. The first is a nonresidential, two-storey 18 building. We are actually looking, if you like, at the 19 back side of the immigration centre. We can see the 20 runway perimeter road, which is at the top of this plan 21 going left to right, so the first building, the one I am 22 describing, the first nonresidential, two-storey 23 building, is the one at the top of this image. That 24 contains the gatehouse, which is the entrance and exit 25 point for members of staff, escort vans and other</p> <p style="text-align: center;">Page 34</p>	<p>1 wings. For ease of reference, at least for now, I am 2 going to refer to them as A, B, C, et cetera, wings.</p> <p>3 A wing, C wing and D wing cover over three floors, 4 or three storeys. On each floor, there are around 20 5 double-occupancy rooms, sometimes referred to by staff 6 members, and indeed others, as cells. They house the 7 detained men. The rooms have two single beds. When 8 capacity was increased in May 2017, 60 of these single 9 beds were replaced with bunk beds so that those rooms 10 could hold three people.</p> <p>11 On the ground floor of each of the wings, there is 12 a wing office where staff members are based, an open 13 area for detained persons with seating, pool and tennis 14 tables, and a food counter where all meals are served. 15 On the first and second floor are corridors from which 16 the rooms can be accessed. There is open space between 17 the floors, covered by wire netting. The wings also 18 have communal showers and laundry rooms. B wing is 19 similar to A, C and D, but B wing only covers two 20 storeys, as against three.</p> <p>21 During the relevant period -- let me remind you, 22 1 April to 31 August 2017 -- B wing was the induction 23 wing where detained individuals were supposed to spend 24 the first few nights of their detention before being 25 moved to one of the other wings.</p> <p style="text-align: center;">Page 36</p>

<p>1 E wing was on the ground floor only and contained 2 space for up to 13 detained persons. Each room had two 3 beds, but they were habitually used for single occupancy 4 only. Two of the rooms were designed for constant 5 supervision, so instead of a small viewing panel, they 6 had large transparent panes looking into the room from 7 the corridor. They were used for men considered to be 8 at risk of self-harm or suicide or those who were on 9 hunger strike. A member of staff would continuously 10 observe the individual from outside the room. The rest 11 of E wing housed individuals who had been placed there 12 for reasons including their mental health, their 13 vulnerability, their violent or difficult behaviour or 14 because they were recently discharged from what was 15 known as the Care and Separation Unit, the CSU. E wing 16 was also used for any detained person suspected to be 17 under 18 years of age.</p> <p>18 Indeed, next to E wing, which was the CSU, that unit 19 had six rooms containing a single bed and no other 20 furniture or amenities. Detained persons would be 21 housed in these rooms if they were separated from 22 association or placed under temporary confinement under 23 what were known as rules 40 and 42 of the Detention 24 Centre Rules 2001. They would be allowed to leave the 25 room for an hour per day, and I am going to return to</p> <p style="text-align: center;">Page 37</p>	<p>1 but the detained men did not have free access within the 2 centre to the various parts or to each other's wings. 3 Also in the main building were rooms which were not 4 accessible to the detained men, including staff canteen, 5 human resources and senior management team offices, 6 which were on the second floor, a security and 7 administration office and a kitchen, although some 8 detained people were employed to work in the kitchen 9 during the relevant time.</p> <p>10 The visit hall was on the first floor -- this is 11 where both social and legal visits would be held -- and 12 within this hall was the welfare office. The 13 Forward Trust office, where detained persons could 14 access support around drug use, was on the first floor.</p> <p>15 I'm going now to deal with the types of issues which 16 are exposed by the evidence that the inquiry has seen. 17 I am going to begin with staffing and the resident 18 population at Brook House. The evidence received by the 19 inquiry has exposed a number of issues at Brook House 20 during the relevant time. For the first, the issue of 21 so-called time-served foreign national offenders, 22 TSFNs, those who have completed sentences of 23 imprisonment and were in detention awaiting deportation. 24 On average, around 35 per cent of those detained at 25 Brook House were TSFNs. G4S and IMB figures suggest</p> <p style="text-align: center;">Page 39</p>
<p>1 the issue of rule 40 and 42 later.</p> <p>2 Next to each wing, at ground level, ground floor 3 level, in the inside of the capital H shape -- I wonder 4 if the image can go back up on screen, please -- was 5 a secure courtyard, and the courtyard was used by 6 detained men for sport or fresh air -- <INQ000062> or 7 <INQ000063>, please.</p> <p>8 I don't know, chair, if there is a gremlin in the 9 system. Would RTS ... I can carry on for the moment.</p> <p>10 The healthcare department was situated on the first 11 floor and contained an office, a GP room, a nurses' 12 clinic and a pharmacy. There was also a room nearby for 13 mental healthcare, and on the ground floor there were 14 two healthcare admissions rooms, for initial assessment. 15 Healthcare was available 24 hours a day, seven days 16 a week. The nurse triage clinic was a walk-in service 17 that was open between 9.30 am and 11.30 am and between 18 2.30 pm and 3.30 pm. The pharmacy opened three times 19 a day for 45 minutes at a time. And the GP service was 20 appointment based.</p> <p>21 The main building also contained communal areas and 22 rooms for the detained population, including a gym, 23 a chapel, a mosque, a multi-faith room, a library, an 24 activity office, a classroom, IT rooms and a craft room. 25 Different parts of the centre were joined by corridors,</p> <p style="text-align: center;">Page 38</p>	<p>1 the average was 33 per cent. Housing TSFNs with those 2 who had no criminal record and had never experienced 3 custody along with men who were often vulnerable due to 4 a past history of torture or mental health problems 5 could be problematic. Chair, you may wish to consider 6 whether the prison-like environment and an atmosphere of 7 intimidation meant that some detained persons did not 8 feel safe, were vulnerable to aggression from other 9 detained persons and likely to experience 10 a deterioration in their mental health.</p> <p>11 Difficulties were particularly created on E wing 12 when those detained persons who were most vulnerable due 13 to a risk of self-harm or suicide, their mental health 14 condition or because they may have been under 18 were 15 housed together with detained persons exhibiting 16 challenging, disruptive or violent behaviour. Detained 17 persons could be sent to E wing for a wide variety of 18 reasons which were not necessarily compatible with the 19 care and welfare of each individual group, particularly 20 in an environment where some staff members appear to 21 have regarded those who were vulnerable as "putting it 22 on" or being deliberately obstructive or manipulative, 23 as opposed to manifesting behaviour due to distress or 24 a deterioration in their mental health.</p> <p>25 You may wish to consider whether there was a general</p> <p style="text-align: center;">Page 40</p>

10 (Pages 37 to 40)

<p>1 problem in Brook House during the relevant period with 2 senior management being or appearing to be inaccessible 3 to the junior management, in other words, not only the 4 detention custody officers, the DCOs, but also the 5 detention custody managers, the DCMs, with very little 6 leadership or interaction taking place. It is for you 7 to consider whether this led to cliques forming in which 8 bad behaviour was not merely tolerated, but admired. 9 From the BBC footage alone, there is evidence of 10 bravado, mockery, macho behaviour and banter, which may 11 have normalised disdain for, degradation of and even 12 violence towards detained persons. 13 You may conclude that Brook House was often severely 14 understaffed. Short staffing appears to have been an 15 almost daily occurrence with the residential wings not 16 having sufficient staff working on them. Members of 17 staff were often not relieved in order to go on a break. 18 The three main residential wings each housed up to 140 19 detained persons. Only two DCOs working on each wing 20 was considered by many to be inadequate to care for 21 detained persons, particularly when part of their duties 22 took one DCO off the wing in order to carry out tasks, 23 leaving only one DCO on the wing. High levels of 24 the management of detained persons on ACDT, which is 25 another acronym we will learn about, the Assessment Care</p> <p style="text-align: center;">Page 41</p>	<p>1 additional 60 beds were introduced into Brook House. 2 This meant that some rooms with a bunk bed and single 3 bed were shared by three men. The staff levels were 4 reported, however, to remain the same, which appears to 5 have created further strain and affected morale. 6 Overcrowding was reported to impact access to 7 healthcare, solicitors' appointments and welfare, with 8 long waits being common. 9 There were often admissions of a number of detained 10 men at a time, sometimes late at night or in the early 11 hours of the morning. On occasions, no interpreters 12 were available. You will hear evidence that detained 13 persons were often confused, frightened and distressed 14 on reception. You may conclude that an unmanageable 15 workload resulted in detained persons waiting for long 16 periods in reception before undergoing first reception 17 screening and admission. 18 You may wish to consider whether a lack of staff 19 also meant that the needs of detained persons were not 20 adequately met at times. Staff members were not able to 21 identify problems in their lives or areas in which they 22 could be helped. Detained persons sometimes could not 23 access cleaning materials or the laundry room when they 24 needed it, or obtain access to recreational areas, 25 whether outside or in the centre or the library or the</p> <p style="text-align: center;">Page 43</p>
<p>1 Detention and Teamwork scheme for managing detained 2 persons at risk of self-harm or suicide, together with 3 constant observations or high levels of intermittent 4 observations, placed an extra burden on detention staff. 5 The workload on DCOs working on the wings and those 6 working in reception was, you may think, consequently 7 often unmanageable. The responsibilities of DCOs 8 working on the wings were wide ranging. They were 9 responsible for a number of tasks, including admitting 10 detained persons to the wing, as I have said, making 11 observations on detained persons subject to ACDT, as 12 well as completing ACDT observation forms, making 13 property appointments, handing out essentials, like 14 toilet roll and soap, checking detained persons' cards 15 as they tried to access the wing, allocating detained 16 persons to rooms, resolving disputes, responding to 17 incidents of violence or self-harm on the wing, 18 escorting detained persons to the kitchen to work and 19 collecting the food trolley from the kitchen. DCOs on 20 the wings were stretched and they were overworked, 21 resulting in them being unapproachable and exhausted. 22 You may wish to consider whether this may sometimes have 23 led to some staff taking their frustrations out on the 24 detained men. 25 In May 2017, something I have already alluded to, an</p> <p style="text-align: center;">Page 42</p>	<p>1 IT room to work on their cases. The range of activities 2 available was reduced due to activities staff covering 3 gaps in staffing on the residential wings. 4 An associated problem was a high turnover of staff 5 and significant difficulties in the recruitment and 6 retention of staff members. This was the case in 7 relation to both detention and healthcare staff. You 8 will hear evidence that often detention staff were 9 inexperienced and left quickly after joining. Many felt 10 unprepared and ill-equipped to deal with the challenging 11 environment of Brook House. Some felt undervalued by 12 management. In healthcare, many of the staff were 13 agency staff and there were vacant permanent positions 14 despite several recruitment drives. 15 You may want to consider whether the range of 16 staffing problems described contributed to 17 dissatisfaction amongst detained persons and a growing 18 feeling of hopelessness and frustration among them, 19 which in turn had an impact on the levels of self-harm, 20 substance misuse and violence at Brook House. The more 21 challenging or non-compliant detained persons became in 22 consequence of their environment, the more some staff 23 resented them for the additional work and stress this 24 added to their lives. Understaffing and overwork was 25 also reported to affect staff morale in a direct sense.</p> <p style="text-align: center;">Page 44</p>

<p>1 The management of healthcare and delivering of 2 clinical care to detained persons in Brook House 3 presented its own challenges. The evidence from 4 formerly detained persons raises concerns that a culture 5 of disbelief persisted in healthcare with doctors and 6 nurses being dismissive of detained persons and 7 exhibiting a lack of care or empathy and a potential to 8 believe that a patient was exaggerating their symptoms, 9 conditions or past history for the purposes of 10 furthering their immigration case.</p> <p>11 The evidence from some healthcare staff, detention 12 staff and formerly detained persons reveals that the 13 problems with understaffing, resourcing, staff 14 recruitment and staff retention may have impacted upon 15 the ability of healthcare staff to deliver adequate 16 healthcare to detained persons on occasions. It was 17 a difficult time within healthcare during the relevant 18 period, which impacted particularly on the reception of 19 detained persons into Brook House, where it was reported 20 by some detention staff that healthcare staff were "run 21 off their feet". Detention staff experienced 22 frustration caused by difficulties in getting hold of 23 healthcare staff. Additionally, where an incident 24 needed a medical emergency response, two members of 25 the healthcare staff were required to respond, which</p> <p style="text-align: center;">Page 45</p>	<p>1 clear, though, is that self-harm and intoxication with 2 spice or other drugs -- and spice is a psychoactive 3 substance and a synthetic cannabinoid -- were 4 significant issues presenting difficult challenges for 5 healthcare staff and that the systems in place for the 6 management of these vulnerable detained persons were not 7 addressing the underlying causes. This resulted in 8 significant diversion of staff and resources to medical 9 emergencies away from other patient care and processes, 10 such as assessments under rule 35 of the Detention 11 Centre Rules of 2001, to which I now come.</p> <p>12 Rule 35(1) of the Detention Centre Rules requires 13 there to be a medical practitioner's report to the 14 centre manager where a detained person's health is 15 likely to be injuriously affected by continued 16 detention, and rule 35(3) requires there to be 17 a separate report where there is concern a detained 18 person has been a victim of torture. Analysis of 19 the evidence available to the inquiry reveals several 20 areas of concern. Issues of understaffing and 21 overcrowding meant that there were sometimes long waits 22 for rule 35 assessments. There are numerous complaints 23 from formerly detained persons concerning the reporting 24 of suicidal thoughts or serious attempts at self-harm or 25 suicide where there was no consideration given to the</p> <p style="text-align: center;">Page 47</p>
<p>1 sometimes took a member of reception staff away from 2 first reception health screening. This would leave 3 detained persons waiting in reception, causing 4 frustration and disruption. Detained persons were often 5 not seen within the required two-hour timeframes and 6 their admission was therefore unduly delayed sometimes 7 by several hours.</p> <p>8 Healthcare staff fulfilling roles related to 9 Home Office requests concerning immigration 10 requirements, such as writing "fitness to fly" letters 11 also sometimes placed pressure on resources and resulted 12 in disruption to the provision of clinical care. Where 13 there were pressures on staffing in one area, such as 14 admissions into reception, another area such as the 15 triage clinic might suffer. There were aspects of 16 healthcare staff's roles in which they felt unsupported 17 by detention staff, such as when DCOs were not available 18 to escort nurses providing medication at night.</p> <p>19 You may want to consider whether the BBC footage 20 relating to relate care incidents, primarily showing 21 healthcare staff's responses to medical emergencies, 22 either involving serious incidents of self-harm and 23 attempted suicide or intoxication, reveals overall an 24 adequate immediate emergency medical response and 25 competent clinical practice on attendance. What is</p> <p style="text-align: center;">Page 46</p>	<p>1 completion of a rule 35 report. Several formerly 2 detained persons recall reporting being a victim of 3 torture to the nurse on first reception health screening 4 or to a mental health nurse, having presented with 5 symptoms of depression, anxiety or post-traumatic stress 6 disorder, PTSD, where no referral to a doctor was made 7 and no rule 35 assessment carried out.</p> <p>8 Of the 76 rule 35(3) reports completed in the 9 relevant period, analysis by Dr Hard suggests that the 10 majority of them -- just over 75 per cent -- were 11 completed inadequately, in that no conclusion was 12 reached as regards the possibility of previous 13 ill-treatment or, in the vast majority of these cases, 14 because no conclusion was reached as regards the impact 15 of ongoing detention. It is also troubling that, 16 despite the requirement to complete a report under 17 rule 35(3) where there was concern a detained person had 18 been a victim of torture, and a separate report under 19 rule 35(1), in the case of a detained person whose 20 health was likely to be injuriously affected by 21 continued detention, there were only two rule 35(1) 22 reports completed during the relevant period. You will 23 hear evidence to suggest that there was no system in 24 place to allow for quality audits of rule 35 reports by 25 the Home Office policy team, despite this being raised</p> <p style="text-align: center;">Page 48</p>

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<p>1 by the head of healthcare with the Home Office.</p> <p>2 Further, the system does not appear to have been</p> <p>3 operating as intended, with a large number of positive</p> <p>4 rule 35(3) reports not resulting in a release from</p> <p>5 detention of the detained person. The inquiry has seen</p> <p>6 rule 35 reports where the doctor's conclusion was that</p> <p>7 the detained person had likely been a victim of torture</p> <p>8 and/or continued detention was likely to be injurious to</p> <p>9 their health. But only 27 per cent of those cases led</p> <p>10 to release from detention.</p> <p>11 Given what is known of the prevalence of serious</p> <p>12 self-harm and suicide attempts during the relevant</p> <p>13 period, you may wish to consider whether it is</p> <p>14 surprising, and indeed concerning, that there were no</p> <p>15 reports completed during the relevant period under</p> <p>16 rule 35, which provides for a report to be made to the</p> <p>17 manager in the case of any detained person suspected of</p> <p>18 having suicidal intentions. That's rule 35(2). There</p> <p>19 doesn't seem to have been any system of referral of</p> <p>20 a detained person to a GP where any member of detention</p> <p>21 or healthcare staff had concerns that he was suicidal,</p> <p>22 whether due to responding to a suicide attempt or an</p> <p>23 incident of serious self-harm or because the detained</p> <p>24 person reported suicidal intentions. No such referral</p> <p>25 was made upon the opening of an ACDT, for example. It</p> <p style="text-align: center;">Page 49</p>	<p>1 during the course of his evidence.</p> <p>2 Let me put up on screen two examples of reports</p> <p>3 issued by medical practitioners in Brook House during</p> <p>4 the relevant period. One is a report under rule 35(3)</p> <p>5 of 13 April 2017 regarding concerns that a detained man,</p> <p>6 D2567, may have been a victim of torture, and the other,</p> <p>7 dated 17 July 2017, is in relation to D1914, whose</p> <p>8 continued detention was regarded as injurious to his</p> <p>9 health. So can we put up on screen first, please,</p> <p>10 <CJS000872> at page 1.</p> <p>11 Here we have a rule 35(3) report. You can see at</p> <p>12 the top it's got the Home Office logo, top left,</p> <p>13 "Removals, Enforcement and Detention Policy.</p> <p>14 Immigration and Border Policy Directorate" is the</p> <p>15 heading. "Annex C". It cites the Detention Service's</p> <p>16 Order 9/2016, detention centre rule 35. This, in</p> <p>17 particular, is a rule 35(3) report:</p> <p>18 "... concerns that a detainee may have been a victim</p> <p>19 of torture."</p> <p>20 Section 1 provides the detainee's details, "D2567".</p> <p>21 "Immigration removal centre: Gatwick Immigration Removal</p> <p>22 Centre", and under section 2 we have:</p> <p>23 "Detainee's authority to release medical</p> <p>24 information."</p> <p>25 Section 3 is the medical practitioner's report:</p> <p style="text-align: center;">Page 51</p>
<p>1 appears it was left to the detained person to request</p> <p>2 such a report.</p> <p>3 The responsibility of a GP completing a rule 35</p> <p>4 report creates an inevitable tension between the forming</p> <p>5 of a doctor/patient relationship with the detained</p> <p>6 person allied with the provision of medical care on the</p> <p>7 one hand, and, on the other, the requirement for an</p> <p>8 analysis of the available evidence in order to determine</p> <p>9 whether a detained person had been a victim of torture.</p> <p>10 The latter role was not one typically undertaken by</p> <p>11 medical professionals and, in particular, GPs, as part</p> <p>12 of their usual responsibilities. This type of analysis</p> <p>13 of evidence and coming to conclusions about its cogency</p> <p>14 was an alien exercise for GPs and, in the absence of</p> <p>15 specific detailed training on how to undertake this</p> <p>16 task, was one which you may think they were ill-equipped</p> <p>17 to carry out.</p> <p>18 Some healthcare staff reported that the lack of</p> <p>19 formal staff induction did not prepare them for their</p> <p>20 role in Brook House and that the training provided was</p> <p>21 insufficient in various areas, such as control and</p> <p>22 restraint, the ACDT process, suicide prevention,</p> <p>23 safeguarding/Adults at Risk and substance misuse.</p> <p>24 Rule 35 and its operation at Brook House during the</p> <p>25 relevant period will be covered in detail by Dr Hard</p> <p style="text-align: center;">Page 50</p>	<p>1 "I have examined the detainee named above in my</p> <p>2 capacity as an immigration removal centre medical</p> <p>3 practitioner and hereby report that I have concerns that</p> <p>4 the detainee may have been a victim of torture. This is</p> <p>5 a factual report rather than a medico-legal one."</p> <p>6 And then sets out the medical practitioner's</p> <p>7 understanding of what torture means in this context.</p> <p>8 Then under section 4, on the next page, please:</p> <p>9 "Please provide details of the account given to you</p> <p>10 by the detainee of the alleged torture."</p> <p>11 Providing as much detail as possible about the</p> <p>12 detainee's explanation for the cause of each injury,</p> <p>13 scar or symptom, and details of when, where, how and</p> <p>14 over what timeframe and why the torture is said to have</p> <p>15 happened.</p> <p>16 Then you have, in this man's case, the medical</p> <p>17 practitioner's history taking:</p> <p>18 "Says he informed Home Office on 1/4/2017 of this</p> <p>19 torture.</p> <p>20 "He escaped Mosul ... made his way to Turkey ...</p> <p>21 "... made to be a slave for three years in Turkey</p> <p>22 for a Kurdish Mafia group [who] beat him with wood to</p> <p>23 the back of the head."</p> <p>24 Gave details about what happened to him sexually</p> <p>25 when aged 13. Had tried to kill himself in Turkey once</p> <p style="text-align: center;">Page 52</p>

<p>1 and twice in this country: 2 "In the IRC ..." 3 In other words, in the immigration removal centre: 4 "... becomes tearful and explains he walks around 5 ashamed thinking that others will know all about him ... 6 "... wants to die. He feels no-one cares about him 7 and there is no place for him. 8 "... difficulty sleeping ..." 9 Has events going back to 2008 when he was 13 and 10 having been physically attacked two months previously in 11 Dunkirk by a group of random men who hit him to the 12 back, but there are no scars present, and so on. 13 Section 5 on page 3 "Relevant clinical 14 observations". Again, details required: 15 "... appears vulnerable. [Has] some scarring to his 16 foot but no other marks. In addition to the scars he 17 has mentioned has also evidence from self-harming [in 18 early April] whilst at the IRC. 19 "Seen by [medical] health team ... difficulty 20 sleeping and displays symptoms of depression and general 21 low mood." 22 Then section 6 on page 4. I wonder if we can zoom 23 in just a bit, please, on these pages. Thank you: 24 "Please set out your reasoned assessment of why, on 25 the basis of the detainee's account together with your</p> <p style="text-align: center;">Page 53</p>	<p>1 2 coronary arterial bypasses. He is currently awaiting 2 a cardiac catheter ablations for abnormal cardiac 3 rhythm. He has intermittently complained of chest 4 during his stay in detention and was recently sent to 5 A&E as healthcare felt he had acutely deteriorated. It 6 is felt that he is a high-risk patient in view of his 7 medical condition and that, though detention is not 8 worsening his condition, the stress may trigger events 9 that lead to another cardiac event." 10 Then the treatment he was receiving, under (ii): 11 "He is awaiting cardiac catheter ablation. His next 12 appointment with the cardiologist is on 18 August. This 13 is a hospital outpatient appointment." 14 Under (iii) at the foot of the page: 15 "Asked about mental health problems. There are 16 none." 17 Then on the next page at the top, section 5, page 3: 18 "What impact is detention or the conditions of 19 detention having (or likely to have) on the detainee's 20 health and why? 21 "See above. Ongoing stress and the unstable nature 22 of his ... condition put his health at risk. 23 "(ii) can remedial action be taken to minimise the 24 risks ... 25 "No.</p> <p style="text-align: center;">Page 55</p>
<p>1 own examination and clinical findings, you are concerned 2 that the detainee may have been a victim of torture." 3 In the final paragraph: 4 "He describes a 3-year period of slavery with 5 periods of physical and sexual abuse (and torture). 6 I think there is a strong likelihood of torture and 7 deterioration in this environment (note self-harm). He 8 appears a credible individual. His scars are consistent 9 with his account despite paucity." 10 So that's that one, just by way of example, as 11 a victim of torture. If we can take that down, please, 12 and go to another one, <CJS001024> at page 1. The same 13 title at the top. This is in relation to D1914, again 14 at Gatwick Immigration Removal Centre. We have 15 section 2, consent. Section 3, "Medical practitioner's 16 report": 17 "I write in respect of the detainee named above ..." 18 Which seems to be a pro forma. This being a report 19 of a detainee whose "health is likely to be injuriously 20 affected by continued detention or the conditions of 21 detention." 22 Page 2, if we may, please, and zoom in at the top, 23 if you would. Can you scroll down? Section 4, 24 "Relevant clinical information": 25 "This man has had two myocardial [infarctions] and</p> <p style="text-align: center;">Page 54</p>	<p>1 "(iii) if the risks to the detainee's health are not 2 yet serious, are they assessed as likely to become 3 so ... [et cetera]. 4 "It is not possible to quantify this but it is felt 5 that he appears worse in health [than] during the early 6 part of his detention. 7 "(iv) how would release from detention affect the 8 detainee's health? 9 "It is suggested that release would reduce his level 10 of stress which [may] reduce the risk. 11 "(v) are there any special considerations that need 12 to be taken into account if the detainee were to be 13 released? ... 14 "Don't know." 15 Those are but two examples of two rule 35 reports 16 under the separate provisions in which medical 17 practitioners at Brook House provided those reports. 18 Let me move on. 19 Drugs misuse. During the relevant period in 20 Brook House, there was what has been referred to by some 21 as a spice outbreak. There was prolific use of spice 22 among detained persons at this time and there was 23 a significant number of incidents involving drugs, 24 including medical emergencies, where healthcare staff 25 were required to respond urgently to incidents of</p> <p style="text-align: center;">Page 56</p>

<p>1 detained persons becoming intoxicated and unwell. We 2 can take this document down. Thank you.</p> <p>3 As I have mentioned before, medical emergencies 4 resulted in the significant diversion of staff, both 5 detention and healthcare, and resources away from other 6 duties. For those detained persons who were vulnerable, 7 the prevalence of drugs and the levels of intoxication 8 created a frightening and unpredictable environment in 9 which their general welfare would undoubtedly have 10 suffered.</p> <p>11 It also provided an opportunity for some detention 12 staff to show what you may think to be their disdain for 13 the detained person. One such instance was that in the 14 case of D1275, who, on 14 June 2017, was filmed by 15 Callum Tulley suffering a spice attack. He was attended 16 to by healthcare but he was mocked by both Nathan Ring, 17 at the time a detention custody manager, a DCM, and 18 a DCO by the name of Derek Murphy. Ring made a series 19 of comments, including, "Keep still, you div", 20 "Scrotum", "Leave him", and "Bucket of cold water will 21 sort out his heart rate, that would do him the world of 22 good", and mocked D1275 for his singing. DCO Murphy 23 said of D1275, "Look at the state of that", "Imagine 24 bringing that home to mother", and, perhaps more 25 chillingly, "Absolutely no sympathy for them at all ...</p> <p style="text-align: center;">Page 57</p>	<p>1 Operating Standards Manual, according to the relevant 2 page of the manual, apparently issued in December 2002, 3 are that: one, the centre will ensure that force is used 4 only in the circumstances I have just described, as 5 quoted. Two, force is only to be used as a last resort 6 and strictly within the terms of rule 41 of the rules of 7 2001. Rule 41 provides that a DCO shall not use force 8 unnecessarily, but where the application of force is 9 necessary, no more force than is necessary shall be 10 used. It also provides that no officer shall act 11 deliberately to provoke a detained person. Moreover, 12 particulars of every case of use of force have to be 13 recorded by the manager and have to be reported to the 14 Secretary of State.</p> <p>15 Third, if handcuffs are used as part of the use of 16 force incident, separate guidance under the Detention 17 Services Order 1/2002 must be adhered to.</p> <p>18 Fourth, the centre must use and purchase training 19 for control and restraint, also known as C&R, techniques 20 from the Prison Service with advance training being 21 carried out by the Prison Service and basic training by 22 the centre's own instructors, provided they have been 23 trained and certified by the Prison Service.</p> <p>24 Fifth, the use of force must only be applied by 25 members of staff who have undertaken necessary training.</p> <p style="text-align: center;">Page 59</p>
<p>1 if he dies, he dies".</p> <p>2 There are allegations of staff bringing in drugs to 3 Brook House, as well as drugs coming in through the 4 visitors hall, with apparently little training or 5 guidance given to staff in how to prevent the smuggling 6 of drugs into the centre and little action taken by 7 management to address the issue or the underlying 8 causes.</p> <p>9 The use of force. The use of force is an issue of 10 great importance to this inquiry. The term "use of 11 force" has a particular meaning in the immigration 12 detention context. According to the Detention Services 13 Operating Standards Manual for immigration removal 14 centres, "force is used only to keep a detainee in 15 custody, to prevent violence, to prevent destruction of 16 the property of the removal centre or of others, and to 17 prevent detainees from seeking to prevent their own 18 removal physically or physically interfering with the 19 lawful removal of another detainee."</p> <p>20 "Force" in this context can embrace many types of 21 physical contact. It can include restraint, holding 22 down, separating, physically moving, pushing/pulling, 23 handcuffing, frogmarching, and so on and so forth.</p> <p>24 The so-called minimum auditable requirements for the 25 use of force, as described in the Detention Services</p> <p style="text-align: center;">Page 58</p>	<p>1 Sixth, if use of force is used, the centre must 2 ensure that detainees are seen by a member of 3 the healthcare team as soon as practicable.</p> <p>4 Seventh, the centre must have a system for recording 5 all incidents of use of force and to monitor its use.</p> <p>6 The inquiry has received and analysed a wide range 7 of documentation concerning each of the 109 use of force 8 incidents recorded by G4S officers as have occurred 9 during the relevant period. The documentation which has 10 been provided by G4S and analysed consists of a vast 11 array of material. Just let me describe what that is: 12 use of force forms completed by DCOs, which provided 13 accounts of what happened; reports of any injuries 14 sustained during the incident; detainee debrief forms; 15 electronic logbooks in which G4S recorded and summarised 16 each incident by month; use of force review meeting 17 forms, which are handwritten, single-page forms in which 18 DCM Steve Webb, who was a C&R, a control and restraint, 19 instructor, reviewed the documentation for each use of 20 force form; Oscar One diaries -- Oscar One was the 21 detention custody manager, the DCM, who had 22 responsibility for the daily running and management of 23 Brook House -- which are handwritten handover logs 24 providing very brief descriptions of notable events each 25 day and evening; there were security and use of force</p> <p style="text-align: center;">Page 60</p>

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<p>1 meeting minutes consisting of PowerPoint presentations 2 and statistics concerning, among other data, use of 3 force incidents; complaints by detained persons; notes 4 from IMB visits; Professional Standards Unit, the PSU, 5 documents; G4S investigation documents; and training 6 records.</p> <p>7 The reviews conducted by DCM Steve Webb require 8 special mention. They were conducted two months after 9 each use of force incident. Having found there to be 10 many missing review meeting forms, the inquiry was told 11 by G4S that use of force incidents were not reviewed at 12 all after September 2017, in other words, for those 13 incidents occurring in June 2017, since those conducting 14 the reviews had been suspended or sacked and were not 15 subsequently replaced.</p> <p>16 As a sample, a use of force review meeting form 17 concerning a detained man, D149, is an example of what 18 could literally be characterised as a tick-box exercise. 19 We will be hearing more about these reviews from 20 Mr Collier in phase 2, but, as a sample, let me ask the 21 evidence handler, please, to put up on screen 22 <CJS000901> at page 1. If we can just scroll it down 23 ever so slightly, please, so we can see the top, thank 24 you, headed "Official -- sensitive" with G4S logo on it, 25 "Use of force review meeting form", detainee name,</p> <p style="text-align: center;">Page 61</p>	<p>1 "Was it necessary? Yes. 2 "Proportionate to the seriousness of the situation: 3 yes." 4 As part of the outcomes of the review, "Lessons 5 learned and further training: no. 6 "No further action required? 7 "No." 8 So that is a typical form. At the bottom, we can 9 see that Mr Webb has signed it and, as we saw, it's 10 dated 21 July 2017 in this instance. 11 The delay in reviewing use of force incidents gives 12 rise to two principal concerns. One, that recollections 13 are likely to fade over the time it took to review these 14 incidents; and, second, that, if reviews were not 15 timely, inappropriate behaviour might be repeated 16 without review or sanction for a long period. It is 17 troubling that, for over half of the relevant period, 18 use of force incidents were not being reviewed at all. 19 In addition to the documentary material I have 20 listed, there is, of course, the BBC footage, which 21 includes footage that was broadcast on the Panorama 22 programme, and unbroadcast footage, and it includes, as 23 I said before, Callum Tulley's video diaries. 24 The inquiry has also received footage from G4S 25 captured by body-worn cameras occasionally worn by the</p> <p style="text-align: center;">Page 63</p>
<p>1 ciphered as D149, some reference numbers of the date of 2 review, 21 July. Name of person completing review, 3 Steve Webb.</p> <p>4 Running from the left column down: 5 "Are all of the use of force reports present: [tick] 6 yes. 7 "Are the documents completed correctly and to an 8 acceptable standard? 9 "[ticked] yes. 10 "Does the incident meet the following criteria? 11 "Reasonable in the circumstances: yes. 12 "No more force than is necessary: yes. 13 "The outcome of this review: 14 "Further investigation required: no. 15 "Letters of commendation required: no." 16 Moving to the top right: 17 "Is the F213 medical form present: yes." 18 That would typically be a body map type form: 19 "Is there CCTV/BWC [body-worn camera]/camcorder 20 evidence which covers this incident? 21 "Yes." 22 Then "Necessary": 23 "I suppose one should read the top box left to right 24 and then the bottom boxes left to right, but, 25 "Necessary", which is one of the criteria:</p> <p style="text-align: center;">Page 62</p>	<p>1 officers, and by CCTV operating at Brook House. 2 As you know, chair, the inquiry has appointed 3 Jonathan Collier, an expert on the use of force, to 4 assess the evidence, and Mr Collier has been asked to 5 provide his expert opinion on 43 key incidents, whether 6 the force used was reasonable, proportionate and 7 necessary. 8 Now, before we break, let me at least start by 9 outlining the complaints process. The policy 10 requirements on handling complaints within immigration 11 detention centres such as Brook House are set out in the 12 detention services order 3 of 2015. Complaints could be 13 made by detained persons by various means, including 14 verbally to a member of G4S or Home Office staff, to 15 a member of the IMB, or by putting a written form into 16 a yellow box at the centre. Additionally, people not in 17 detention, such as friends or family members, NGOs and 18 solicitors could raise concerns in writing with G4S or 19 with the Home Office. 20 Part of the Home Office's contract monitoring role 21 involved ensuring that complaint forms were available in 22 every residential unit and in the library. They were 23 translated in up to 20 languages. 24 According to G4S Care and Justice Services' 25 corporate statement, all detained persons had access to</p> <p style="text-align: center;">Page 64</p>

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<p>1 the Home Office complaints system, and anyone could 2 complete a complaints form and post it in the 3 Home Office post box on each unit. Once a complaint was 4 made by a detained person, it was the Home Office's role 5 to collect forms from the locked boxes each morning and 6 pass them on so that they could be distributed to the 7 correct place. They would be received by the Detention 8 and Escorting Services, the DES, Complaints Unit, who 9 would filter them based on the seriousness of 10 the complaint, making a decision about whether it should 11 be investigated by G4S, the Home Office PSU, the 12 Professional Standards Unit, or indeed by NHS England. 13 The PSU is part of the Home Office but it sits within 14 a different directorate to detention and escorting 15 services and immigration enforcement. 16 Mark Hartley-King, the assistant director assigned to 17 the PSU at the relevant time, says that this helps to 18 ensure the independence of the PSU from the DES, from 19 the detention and escorting services part of 20 the Home Office. 21 Allegations of minor misconduct or about conditions 22 or facilities within Brook House would be investigated 23 internally by G4S. They would usually be allocated to 24 a senior manager, who would then ask a DCM, a detention 25 custody manager, to investigate. This might include</p> <p style="text-align: center;">Page 65</p>	<p>1 investigation. This could be commissioned immediately 2 after the complaint or incident, or could follow an 3 initial G4S investigation. However, the inquiry is 4 aware of at least two instances where complaints were 5 not passed to the PSU in a timely manner in relation to 6 one complaint, a complaint by D2953 and a complaint by 7 D1538. More of which, with your permission, at 2.00 pm, 8 chair. 9 THE CHAIR: Thank you very much. Yes, we will return at 10 2.00 pm. Thank you, Mr Altman. 11 (12.58 pm) 12 (The short adjournment) 13 (2.00 pm) 14 MR ALTMAN: Chair, before we broke, I was dealing with the 15 issues of complaints, and I had told you that the 16 inquiry was aware of at least two instances where 17 complaints weren't passed to the PSU in a timely manner. 18 One of those was in relation to a complaint by 19 a detained person ciphered as D2953. In his case, he 20 had contacted G4S's Equalities Advisory Support Service 21 by telephone on 10 June 2017, and made further calls, 22 including on 16 June, when he stated he had been 23 assaulted three times by a staff member. D2953 said 24 that he was at Brook House but, for whatever reason, the 25 helpline didn't know that G4S ran Brook House. During</p> <p style="text-align: center;">Page 67</p>
<p>1 interviewing the detained person who made the complaint, 2 any relevant staff or other detained persons, and 3 viewing CCTV or other evidence. Ultimately, a letter 4 was then sent to the detained person setting out the 5 findings in response to their complaint. These 6 responses would be dip-sampled by the Home Office on 7 a monthly basis to assess quality. 8 Although there was a 20-day turnaround time for 9 complaints, staffing pressures meant that managers had 10 fallen behind by as much as a month. 11 G4S's requests and complaints policy in force during 12 the relevant time provided that a complaints coordinator 13 would maintain a register of written complaints and the 14 outcome of them. The policy also required a monthly 15 complaints report to be compiled, informing senior 16 management of all of the complaints received during the 17 previous month and offering comparisons on a quarterly 18 basis for trend analysis purposes. This report was 19 required to detail the nature of the complaints, their 20 outcomes, which areas actioned the investigations, their 21 categories and the nationalities of the complainants. 22 It does not appear that monthly reports were produced 23 during the relevant period. 24 Allegations of serious misconduct against G4S or 25 Home Office staff should have led to a PSU</p> <p style="text-align: center;">Page 66</p>	<p>1 one call, the helpline operator asked him if he wanted 2 her to notify someone in Brook House about what was 3 happening to him, but this was never followed through. 4 The matter ended up being recorded as a whistleblowing 5 issue on 24 September, some three months after, and it 6 was initially allocated for investigation by G4S. Even 7 at that stage, it was not referred to the Home Office, 8 on the basis that there was "no evidence that an assault 9 had taken place". 10 By the time it was referred to the Home Office, and 11 then the PSU on 13 November, it was already being 12 investigated because a separate complaint had been made 13 by D2953's solicitors in a letter before action of 14 28 September 2017 addressed to the Home Office. In an 15 email of 14 November 2017, Mark Hartley-King, someone to 16 whom I have already referred -- he, at the time, was an 17 assistant director assigned to the PSU -- wrote: 18 "The way things are being mishandled at Brook is not 19 great." 20 D2953's complaints were in fact substantiated and 21 the PSU reached the conclusion that he had been 22 assaulted on three occasions by a G4S staff member, 23 Derek Murphy. I am going to ask to be put up on screen 24 some pages of the PSU investigation report. Let's begin 25 with the title page, which is <CJS001506> at page 1.</p> <p style="text-align: center;">Page 68</p>

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<p>1 Forgive me, it should be at page 20 of this document. 2 So for the first page of the investigation report, the 3 title page. There we have it. "Home Office Security 4 Professional Standards Unit": 5 "A Home Office investigation into the circumstances 6 surrounding the treatment of Mr D2953 who states he was 7 assaulted by ... (DCM) Derek Murphy on 10, 11 and 8 12 June 2017 whilst at Brook House ..." 9 We can see who the investigating officer was, 10 Rukshana Rafique. If we then go, please, within this 11 document to page 32, and if we just scroll down to the 12 bottom half of the page, "Consideration of evidence and 13 conclusions": 14 "Allegation 1: On 10 June 2017 DCM Murphy hit him 15 hard on his left thigh leaving a bruise, on 11 June ... 16 punched him on the chest/lower abdomen and, on 16 June 17 he punched him on the left side of his head." 18 Those were the allegations that were made, 19 consolidated into one allegation. We can see the report 20 then continues with a review into D2953's complaints. 21 I'm not going to go through that now, but if we go on, 22 please, to I think what would be page 35, at 7.2 we have 23 the conclusion: 24 "Crucially, some of this mistreatment by Acting DCM 25 Murphy was around the same time ..."</p> <p style="text-align: center;">Page 69</p>	<p>1 including: interviewing the complainant -- ideally in 2 person, or alternatively by phone or via their 3 representatives; obtaining relevant documents, such as 4 use of force reports, or medical records; obtaining 5 relevant footage, such as CCTV or body-worn camera 6 footage; and interviewing the staff who are subject to 7 the complaint and any relevant witnesses. 8 As provided in the Detention Services Order 3/2015, 9 when dealing with allegations of serious misconduct, the 10 PSU had to provide a substantive report within 12 weeks. 11 There are several occasions in which this target does 12 not appear to have been met. 13 Even where a complaint is withdrawn by a detained 14 person, the investigation should continue to 15 a conclusion unless the detained person has explicitly 16 asked for it to stop. There have been three withdrawals 17 from PSU investigations into Brook House since 2012. 18 The PSU's evidence suggests that any allegation 19 containing an element of criminality is referred to the 20 local police, if this had not already happened, such as 21 in cases where there is an allegation of assault. 22 Although there is evidence of this having happened in 23 some cases, it did not appear to happen in every case. 24 Police investigations can proceed in parallel to, or 25 take priority over, PSU investigations, but in several</p> <p style="text-align: center;">Page 71</p>
<p>1 That's a reference back to evidence that Mr Murphy 2 had been interacting with other detainees in not 3 dissimilar fashion: 4 "... as when Mr D2953 alleges he was mistreated by 5 Officer Murphy. On a balance of probabilities [which is 6 the test applied] it is therefore right and proper for 7 this investigation to attach weight to the information 8 contained within the ... Panorama programme when 9 assessing Mr D2953's allegations against ... Murphy." 10 And on it goes. Then over the page, please, to what 11 should be -- the next page, please. And can you scroll 12 up? At paragraph 7.2.4, in bold: 13 "Therefore, on a balance of probabilities the 14 conclusion reached ... there is substance to ... 15 allegations, consequently the allegation is 16 substantiated." 17 Then we can see that it is followed by 18 recommendations. So that is the format of PSU 19 investigation reports. I'm only bringing this one up as 20 a sample. But referable to the case which I was just 21 describing. Thank you. That can go down. 22 On each occasion when a complaint is passed to the 23 PSU, an investigating officer will be allocated, who 24 bears responsibility for carrying out the investigation. 25 Their role will be to gather relevant evidence,</p> <p style="text-align: center;">Page 70</p>	<p>1 cases, the evidence suggests that police waited for the 2 PSU to complete its investigation before deciding 3 whether to take any further action, such as in D2953's 4 case. 5 The investigating officer will produce a report 6 summarising the allegations, the evidence gathered, 7 findings and recommendations, as we have just seen. 8 Ultimately, it is for the investigating officer to come 9 to a conclusion in relation to each allegation, as to 10 whether the available evidence substantiates the 11 complaint, again, as we saw, on the balance of 12 probabilities. However, the case will be reviewed by 13 a senior investigating officer also. A response letter, 14 in similar but not exactly the same terms as the report, 15 will be sent to the complainant. 16 Chair, you may want to consider some of 17 the weaknesses identified in relation to the complaints 18 process during the relevant period. They include: the 19 lack of process at the time for recording and tracking 20 informal complaints; the perception that complaints are 21 submitted to the Home Office and referred to G4S for 22 investigation, deterring people from raising complaints 23 "due to potential repercussions or lack of credible 24 investigation", and that comes from the witness 25 statement of Michelle Smith, from whom we will be</p> <p style="text-align: center;">Page 72</p>

<p>1 hearing early next week, but in relation to scene 2 setting only; or, third, the spreadsheet recording all 3 complaints containing or relating to allegations of 4 misconduct by staff did not include or cross-refer to 5 allegations which had not been the subject of a formal 6 complaint but had come to light via the security 7 incident report, SIR, process, use of force reports, HR 8 reports or any other way.</p> <p>9 Once a PSU investigation has been completed, it is 10 for the Home Office to consider the findings and any 11 appropriate action. This may include consultation with 12 senior management at Brook House. Where allegations 13 against staff are substantiated by investigation, the 14 matter is referred, as appropriate, to the G4S centre 15 manager, head of healthcare or appropriate Home Office 16 line manager to consider action.</p> <p>17 Many PSU investigations were commissioned 18 specifically to include the identifications of lessons 19 to be learned and recommendations. Some of 20 the recommendations in reports seen by the inquiry 21 include: individual training for specific officers; the 22 need for staff to be reminded of their responsibility to 23 respond to and document all complaints raised to them by 24 detained persons; addressing concerns held by detained 25 persons about using the formal complaints process and</p> <p style="text-align: center;">Page 73</p>	<p>1 which these many recommendations were heeded and, in 2 some cases, whether a quicker investigation process may 3 have led to action being taken at an earlier stage, 4 which could have prevented subsequent mistreatment. 5 I should also add that there was a separate complaints 6 process for investigating complaints about healthcare 7 provision or the conduct of healthcare staff whereby 8 those complaints would be investigated by G4S healthcare 9 or NHS England. And of course the PPO's office, of 10 which you would be well aware, also had a role in terms 11 of hearing appeals arising from complaints in 12 immigration detention. We are going to hear more about 13 that in phase 2.</p> <p>14 In response to the Panorama programme, the 15 Home Office initially chose to rely upon a G4S-led 16 investigation into the relevant staff members. However, 17 in October 2017, litigation was initiated on behalf of 18 some detained persons in relation to allegations of 19 abuse and procedural failings at Brook House. This led, 20 in November 2017, to the PSU being commissioned by the 21 Home Office for a specific investigation into ten claims 22 stemming from Panorama.</p> <p>23 Let me now come on to monitoring and compliance. 24 Assessment of G4S's performance relied upon engagement 25 with detained persons, analysing data such as staff</p> <p style="text-align: center;">Page 75</p>
<p>1 discussing with them about why they do not formally 2 complain; the need to activate body-worn cameras; the 3 need for Home Office staff at Brook House to ensure 4 that, during their contact with detained persons, any 5 serious allegations and complaints are identified; the 6 need for Home Office staff to monitor body-worn camera 7 footage and observe incidents and planned use of force; 8 the need to record all use of force; reminding all staff 9 of the actions to be taken when a detained person alerts 10 them to any form of mistreatment; and for G4S to review 11 and ensure that their complaints handling process is 12 robust enough to prevent a similar situation, as 13 happened in D2953's case, from happening again.</p> <p>14 Prior to the relevant period, other recommendations 15 included reminding staff of the need to report 16 inappropriate conduct -- that was in 2012 -- and the 17 need to report alleged assaults -- 2015. There appears 18 to have been a team within the Home Office whose mailbox 19 address was 20 "DetentionOpsLessonsLearned@Home Office.gsi.gov.uk" who 21 were responsible for ensuring lessons were learned from 22 investigation reports and for monitoring the 23 implementation of recommendations from the Prisons and 24 Probation Ombudsman and other oversight bodies. 25 Chair, you may want also to consider the extent to</p> <p style="text-align: center;">Page 74</p>	<p>1 attendance, rule 40, which is removal from association, 2 rule 42, temporary confinement, documents, use of force 3 reviews, speaking to staff and carrying out checks on 4 things like the cleanliness of the centre and 5 dip-sampling complaints responses.</p> <p>6 However, there was a lack of capacity to undertake 7 contract monitoring within the onsite Home Office team 8 and performance measurement relied "very heavily" on 9 self-reporting by G4S of any service failures, which 10 would be added to any performance failures identified by 11 the Home Office and inserted into a so-called 12 "mitigation log".</p> <p>13 Chair, I'm being asked to pause for a few minutes 14 because there is a transcription issue.</p> <p>15 THE CHAIR: Okay, thank you. Yes, we will take a break for 16 five minutes. Thank you. Return at 2.25 pm. 17 (2.20 pm)</p> <p>18 (A short break)</p> <p>19 (2.32 pm)</p> <p>20 THE CHAIR: My apologies for the pause, but I think we are 21 back up and running. 22 MR ALTMAN: Sort of. 23 THE CHAIR: I will let you fill in the details. 24 MR ALTMAN: Chair, my understanding is that there have been, 25 as I think most people know, WiFi issues, and apparently</p> <p style="text-align: center;">Page 76</p>

<p>1 the transcription service over here, which relays to 2 some of those screens over there and perhaps screens 3 around me, is not working as it should be, and 4 I understand that's a WiFi issue. If that issue 5 persists, any missed parts of my opening can be provided 6 to those who are interested in having it during the 7 course of the afternoon or perhaps later, but hopefully 8 the whole transcript will be on the website later this 9 evening, in any event. I think I have understood it 10 correctly.</p> <p>11 THE CHAIR: Thank you.</p> <p>12 MR ALTMAN: Let me just rewind. I was dealing with 13 monitoring and compliance. I told you, chair, that 14 there was a lack of capacity to undertake contract 15 monitoring in the onsite Home Office team, and that 16 performance measurement relied "very heavily" on 17 self-reporting by G4S of any service failures, which 18 would be added to any performance failures identified by 19 the Home Office and inserted into a so-called 20 "mitigation log", and that's where I had finished.</p> <p>21 Now, according to Alan Gibson, who was head of 22 operations, formal monitoring focused mainly on staffing 23 levels, measured in hours, declared by G4S. Ian Castle, 24 the detention and escorting service manager for Gatwick 25 Immigration Removal Centres from July 2017, admitted</p> <p style="text-align: center;">Page 77</p>	<p>1 D1527 and a DCO about whom we will hear more, 2 Yan Paschali.</p> <p>3 In May 2017, there was one reported "serious 4 complaint" relating to a detained person who said he 5 left Brook House without his bag of property and four 6 "other complaints", all of which were fully or partially 7 substantiated, and included an allegation of a detained 8 person being verbally abused by a member of staff, and 9 an allegation from 2015 regarding medical 10 confidentiality.</p> <p>11 In June 2017, there were two apparently "serious 12 complaints", one relating to a detained person who was 13 transferred and did not get his boots, and the other 14 relating to a detained person who didn't receive cash 15 sent to him. The only "other complaint" noted was about 16 an absence of cleaning products.</p> <p>17 In July 2017, there was one "serious complaint" 18 about property having been left behind and two "other 19 complaints" about meals and payment for work.</p> <p>20 In the final month of the relevant 21 period, August 2017, there were two "serious 22 complaints" -- one about a detained person not being 23 paid for work and another about a detained person not 24 being let out of his room on two occasions to carry out 25 his cleaning duties and being called an inappropriate</p> <p style="text-align: center;">Page 79</p>
<p>1 that they probably did not go beyond contractual 2 obligations to determine whether Brook House was "a good 3 enough place", "being well enough run" or whether "the 4 experience of detainees [was] good enough".</p> <p>5 We understand that the process for monitoring 6 performance included weekly meetings for both sides to 7 raise issues or failures, monthly meetings to discuss 8 penalty points, and quarterly meetings focused on 9 long-term commercial aspects of the contract. Any 10 failures would be inputted into a spreadsheet and then 11 addressed during weekly meetings between the Home Office 12 and G4S, taking into account any mitigation put forward 13 for a breach. However, we have not seen minutes for 14 these weekly meetings.</p> <p>15 Details of penalties imposed under the contract 16 included regular performance management reports written 17 by G4S. We have received reports relating to each month 18 of the relevant period. Some of the notable findings 19 are:</p> <p>20 In April 2017, there were reported to be no "serious 21 complaints", which was a term of art, and one "other 22 complaint", another term of art, about handcuffs not 23 being properly applied during escort to hospital. This 24 was the month during which Panorama showed a number of 25 serious incidents, including the incident involving</p> <p style="text-align: center;">Page 78</p>	<p>1 name by an officer. The other "other complaint" related 2 to a detained person's visiting partner not being 3 allowed to breastfeed.</p> <p>4 Chair, in light of the number of incidents and 5 complaints about which you will hear evidence, you may 6 want to consider why only these few matters were 7 identified and recorded for contractual purposes during 8 the relevant period.</p> <p>9 You will also note that the vast majority of events 10 which are identified as "untoward events", or so-called 11 "untoward events" appear to relate to failures to 12 produce a detained person for an official or legal or 13 case-related visit within 15 minutes.</p> <p>14 In addition to this regular monitoring, the 15 Home Office's Detention and Escorting Assurance and 16 Audits Team -- here's another acronym; DESAAT -- 17 undertook contract compliance checks twice yearly and 18 carried out thematic reviews on specific topics. At 19 a more senior level, a formal Executive Oversight Board 20 was held by the Home Office every three months to 21 discuss contractors' performance. It was chaired by 22 a senior civil servant from the Home Office Commercial 23 directorate, and attended by Immigration Enforcement.</p> <p>24 According to Ian Castle, in late 2017/early 2018, 25 "a new method of measuring contract compliance was</p> <p style="text-align: center;">Page 80</p>

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<p>1 introduced by the Home Office, in that staff were given 2 specific areas to monitor, including reception/induction 3 process, detainee welfare, catering/cleaning, among 4 others. The team met on a monthly basis to discuss any 5 issues, particularly those that were not being 6 addressed. Care and welfare was considered particularly 7 important by the Home Office and Home Office staff 8 attended weekly detainee welfare forums."</p> <p>9 Let me come on now to senior management team and 10 security team meetings. At a senior management team 11 meeting, the acronym being SMT, in June 2016, under the 12 heading of "Audits & Compliance", and following the 13 entry "Updated on penalty points", it was noted that 14 there was an appeal against the outcome of two PSU 15 complaints. This might suggest, at least at this time, 16 that G4S had been penalised under the contract for 17 conduct which led to a PSU complaint being upheld. 18 However, we have not seen any evidence as to whether 19 there were any such penalties during the relevant 20 period.</p> <p>21 Similarly, in a December 2016 meeting, it was noted 22 under the "Audits & Compliance" legend that "2 incident 23 reports for UoF", which is short for use of force, "were 24 not submitted within 24 hours with one offering no 25 mitigation and the other was down to confusion as</p> <p style="text-align: center;">Page 81</p>	<p>1 team -- meeting in September 2017, Barry Timms, the 2 audits and compliance manager, noted that "staff do not 3 understand what failures are subject to penalty points" 4 and pointed to an inability to mitigate repeated 5 incidents, rising failures relating to escort paperwork 6 and failure of an escort, and there were heavy penalties 7 relating to the IT suite.</p> <p>8 Chair, moving, then, away from those issues, let me 9 now please set out some facts and figures under separate 10 heads. First of all, the detained population.</p> <p>11 As you appreciate, Brook House held men detained 12 under immigration powers from all over the world. 13 During the relevant period, records provided to the 14 inquiry show that the most common countries of origin of 15 those detained at Brook House were, in order, India, 16 Albania, Pakistan, Nigeria and Bangladesh.</p> <p>17 During the relevant time period, monthly statistics 18 show that the average population varied from 435 to 465 19 men, with an average occupancy of 446 in detention over 20 the period. On average, 35 per cent of those detained 21 at Brook House were time served foreign national 22 offenders, TSFNs, those who had completed sentences of 23 imprisonment and were in detention awaiting deportation.</p> <p>24 Staffing levels. The terms of the contract as 25 originally agreed between G4S and the Home Office</p> <p style="text-align: center;">Page 83</p>
<p>1 whether [is the way it reads] it was a UoF". 2 Performance management reports provide evidence that 3 penalty points were awarded for late submission of use 4 of force documents. One example falls just outside the 5 relevant period in the month ending November 2017. 6 However, in the relevant period, in the months 7 ending April, May, June and July 2017, no points were 8 awarded for late submission of use of force reports. In 9 the month ending August 2017, points were awarded for 10 what appears to have been late delivery of an incident 11 report, which included the use of force on a detained 12 man -- that was D1249 -- on 11 August. The Home Office 13 did not accept G4S's attempt to mitigate the points 14 awarded.</p> <p>15 During a senior management team meeting 16 in October 2016, Mr Saunders, the then centre director, 17 noted that there was a need to make sure that DCMs were 18 aware of the contract requirements to try and alleviate 19 failures and penalty points. During another senior 20 management team meeting, this time in April 2017, 21 Mr Saunders noted that this was the last year of 22 the contract and that the Home Office were pushing back 23 on the mitigation that G4S were offering against 24 penalties for performance failures.</p> <p>25 At a security -- as distinct from senior management</p> <p style="text-align: center;">Page 82</p>	<p>1 provided that, where centre capacity was 91 to 2 100 per cent, between 8.00 am and 9.00 pm there should 3 be three DCMs and 35 DCOs on duty, 34 at the weekend, 4 and, between 9.00 pm and 8.00 am, two DCMs and 11 DCOs 5 on duty. During the relevant period, the contract 6 between G4S and the Home Office stipulated that 7 668 hours of DCO time should be provided each weekday, 8 655 at weekends, and it required at least two DCOs to be 9 on duty on each residential wing during the day. It is 10 believed that the contractual specifications had moved 11 away from the number of staff on duty as originally 12 contracted to the number of staffing hours during the 13 relevant period.</p> <p>14 At full capacity, and following the increase in bed 15 numbers in May 2017, when 60 rooms, you will remember, 16 were converted into triple occupancy, a wing could house 17 up to 150 men, meaning a ratio of one DCO to 75 detained 18 men if both DCOs remained on the wing. During the 19 relevant period, there were 13 days on which the minimum 20 DCO staffing level was not met. All of them were 21 between June and August, and almost always during 22 weekends. On four occasions, staffing was 90 per cent 23 of the minimum level or below.</p> <p>24 Let me return to contract points deductions. Over 25 the life of G4S's contract with the Home Office,</p> <p style="text-align: center;">Page 84</p>

<p>1 deductions represented on average around 1.5 per cent of 2 the monthly fee. Between April and August 2017, G4S 3 incurred 19,245 penalty points under the terms of 4 the contract, amounting to a financial deduction of 5 £32,153.84. During the relevant period, neither verbal 6 abuse of a detained person nor inappropriate use of 7 force constituted performance failures. Review of 8 the BBC Panorama footage by G4S and the Home Office led 9 to the identification of 84 incidents, most of which had 10 been reported under the contract, or were not reportable 11 events under the contract. G4S was charged £2,768 by 12 the Home Office in respect of eight of these incidents.</p> <p>13 An investigation by the National Audit Office 14 published in July 2019 concluded that, until 2018, the 15 Home Office did not have the people in place properly to 16 verify or validate G4S's reported level of performance, 17 echoing Alan Gibson's account of a lack of capacity to 18 undertake contract monitoring within the Home Office 19 onsite team, so that performance measurement relied, as 20 he put it, very heavily on G4S self-reporting service 21 failures. The National Audit Office noted that "the 22 onsite monitoring of G4S's contractual compliance was 23 part of one executive officer's role, a junior civil 24 servant, who sat in the detainee casework team and 25 focused mainly on monitoring G4S's level of staffing.</p> <p style="text-align: center;">Page 85</p>	<p>1 removal process. Force was used on a detained person to 2 obtain his thumbprint for the person's High Commission 3 to produce an emergency travel document where he had 4 been interviewed but had refused to comply with 5 requests.</p> <p>6 Self-harm. Records provided to the inquiry 7 collating instances of self-harm by detained persons 8 show that, during the relevant period, 60 instances of 9 self-harm were reported. More than one of those 10 instances might have related to a single person, as each 11 instance is recorded as a new event. However, this 12 amounts to a recorded average of 12 acts of self-harm 13 per month at Brook House during the relevant time. 14 A detained person required treatment offsite as a result 15 of an act of self-harm four times during the relevant 16 period.</p> <p>17 Assaults. G4S recorded various data on violent 18 occurrences within Brook House. The records for the 19 five-month period which the inquiry is focusing on show 20 there were: 30 assaults by detained persons on other 21 detained persons, so six a month, on average; 67 22 assaults by detained persons on members of staff, so 23 almost 13.5 a month, on average; one assault by a member 24 of staff on a detained man, D2034; and 192 recorded 25 threats of violence by detained persons, almost 38.5</p> <p style="text-align: center;">Page 87</p>
<p>1 This was insufficient to enable the Home Office to 2 properly examine G4S's self-reported performance or 3 challenge G4S on its management of the centre".</p> <p>4 Following the broadcast of the Panorama programme 5 and a number of reviews and reports into Brook House, 6 the Home Office increased the size of both its onsite 7 compliance management team and its onsite detainee 8 engagement and casework team.</p> <p>9 Use of force. Each month, in security meetings, G4S 10 reviewed, among other things, the number, type and 11 reason why use of force was used against detained 12 persons. The number of use of force incidents would 13 vary significantly from month to month; from 30 14 in April 2017 to 10 in August 2017. The vast majority 15 were unplanned incidents. During the relevant period, 16 maintaining good order and discipline was overwhelmingly 17 the principal reason provided by G4S staff as to why 18 force was necessary. From the inquiry's analysis of 19 the use of force documentation provided by G4S, this was 20 provided as a justification for mostly unplanned use of 21 force incidents. For example, in order to maintain good 22 order and discipline, force was used to escort detained 23 persons around the centre if they did not comply with 24 instructions. In one instance, this justification was 25 employed in order to assist with the Home Office's</p> <p style="text-align: center;">Page 86</p>	<p>1 a month.</p> <p>2 Incident reports and serious incident reports -- IRs 3 and SIRs -- were completed in a wide range of 4 circumstances, including weapon seizures, drug taking 5 and possession, fights and escape attempts. During the 6 relevant period, G4S found that, while TSFNs comprised 7 35 per cent of the detained population, they were 8 involved in 51 per cent of serious incidents reported, 9 and in 50 per cent of all other reported incidents.</p> <p>10 Drugs. As to the prevalence of drugs at 11 Brook House, the incident reports show that, during the 12 relevant period, there were 190 recorded drug-related 13 incidents, or an average of 38 per month. This might 14 mean drugs or drug paraphernalia being found in the 15 centre, actual or suspected drug use by a detained 16 person, abuse of prescription medication, actual or 17 suspected reports of visitors trying to bring drugs into 18 the centre, as well as drug trafficking.</p> <p>19 Back to rule 35. During the relevant period, 114 20 rule 35 reports were received in respect of men detained 21 at Brook House. In 31 cases, this led to the release of 22 the individual. These were completed both by doctors 23 working for G4S Health Services and by external 24 clinicians, sometimes under the instruction of 25 individuals' legal representatives or charitable</p> <p style="text-align: center;">Page 88</p>

<p>1 organisations.</p> <p>2 Rules 40 and 42. Rules 40 and 42 of the 2001 rules</p> <p>3 provide a power to those managing detention centres to</p> <p>4 impose further restrictions of freedom on those in</p> <p>5 detention, where it is necessary for reasons of safety</p> <p>6 or security. Neither rule 40 nor rule 42 powers should</p> <p>7 be used as punishment, and both should only be used as</p> <p>8 a last resort, when other measures have failed or are</p> <p>9 likely to fail.</p> <p>10 Rule 40, as I have said before, relates to "removal</p> <p>11 from association" and it provides that a detained person</p> <p>12 can be taken away from other detained persons and</p> <p>13 accommodated in certified rule 40 accommodation within</p> <p>14 the CSU. During the relevant period, there were 241</p> <p>15 occasions on which the rule 40 power was recorded as</p> <p>16 having been used. A number of these occasions will</p> <p>17 relate to the same individual. During that same period,</p> <p>18 rule 40 was employed 48 times a month, on average.</p> <p>19 Rule 42 provides that a refractory or violent person</p> <p>20 can be temporarily confined in special accommodation,</p> <p>21 also in the CSU. This power must not be used after the</p> <p>22 person has ceased being refractory or violent. During</p> <p>23 the relevant period, the rule 42 power is recorded as</p> <p>24 having been used twice.</p> <p>25 Finally, for this section of this opening statement,</p> <p style="text-align: center;">Page 89</p>	<p>1 not have clear evidence yet.</p> <p>2 Chair, that completes the second section of</p> <p>3 the opening statement. When I commence section 3, that</p> <p>4 will be to come into detail to look at the evidence, in</p> <p>5 particular Callum Tulley and the Panorama programme, so</p> <p>6 can I suggest, it being 3.00 pm, perhaps being a little</p> <p>7 earlier than we might otherwise have done, that we have</p> <p>8 a 15-minute break?</p> <p>9 THE CHAIR: Thank you. We will return at 3.15 pm.</p> <p>10 (3.00 pm)</p> <p>11 (A short break)</p> <p>12 (3.18 pm)</p> <p>13 THE CHAIR: Chair, I'm now going to summarise some of</p> <p>14 the evidence to be heard during phase 1 of these</p> <p>15 hearings, and I begin, as I said a little earlier, with</p> <p>16 Callum Tulley and the BBC's Panorama programme.</p> <p>17 Callum Tulley is currently a BBC journalist. His</p> <p>18 connection with Brook House began when he responded to</p> <p>19 an advertisement for an assistant custody officer, an</p> <p>20 ACO, at Gatwick IRC. He applied online and was invited</p> <p>21 in for interview at Brook House, and he got the job. He</p> <p>22 became an employee of G4S at Brook House on</p> <p>23 6 January 2015, and he left, in circumstances to which</p> <p>24 I shall come, about two and a half years later, on</p> <p>25 7 July 2017.</p> <p style="text-align: center;">Page 91</p>
<p>1 complaints, G4S and the IMB kept a record of the number</p> <p>2 of complaints made against G4S by detained persons.</p> <p>3 During the relevant time period, IMB and G4S combined</p> <p>4 reports show that 76 complaints were recorded. Twelve</p> <p>5 complaints were wholly or partly substantiated during</p> <p>6 that period. A G4S spreadsheet on complaints suggests</p> <p>7 40 complaints were received during the relevant period.</p> <p>8 They included complaints about unfair treatment,</p> <p>9 homophobic comments, alleged assault, harassment by</p> <p>10 other detained persons, missing property, failure to</p> <p>11 provide medication, et cetera. We shall have to await</p> <p>12 phase 2 to see if the numbers can be reconciled.</p> <p>13 From our own analysis of the disclosure received by</p> <p>14 the inquiry, we found a further four complaints wholly</p> <p>15 or partly substantiated after the relevant period,</p> <p>16 relating to events taking place during the relevant</p> <p>17 period, all by the PSU. These included staff damaging</p> <p>18 the property of D642; failing to take action in response</p> <p>19 to a complaint by D668 that another detained person</p> <p>20 threw a bucket of water on him; assault and derogatory</p> <p>21 comments by staff towards D1527; a staff member</p> <p>22 assaulting D2953 on three occasions within six days,</p> <p>23 which I have already mentioned. And this excludes any</p> <p>24 complaints made directly to the PPO, the Prisons and</p> <p>25 Probation Ombudsman, and NHS England, about which we do</p> <p style="text-align: center;">Page 90</p>	<p>1 He undertook his training for the ACO role and later</p> <p>2 applied to become a DCO, and following an assessment, he</p> <p>3 received further training over six weeks, which involved</p> <p>4 corporate training, in other words, G4S corporate</p> <p>5 training, searching detained persons and cells, or</p> <p>6 rooms, first aid, fire safety, control and restraint,</p> <p>7 diversity and inclusion and how to deal with</p> <p>8 self-harming and suicidal detained persons. One focus</p> <p>9 of the training was on the use of force and the</p> <p>10 Detention Centre Rules, which make provision for the</p> <p>11 regulation and management of detention centres and</p> <p>12 provide for the welfare and privileges of detained</p> <p>13 persons, religious observance, correspondence,</p> <p>14 healthcare and any complaints they wish to make, as well</p> <p>15 as the use of security measures, such as powers of</p> <p>16 search and removal from association in certain</p> <p>17 circumstances. Callum Tulley was assigned to the</p> <p>18 activities department.</p> <p>19 He recalls being told they may only use force when</p> <p>20 it was absolutely necessary and, when it was necessary,</p> <p>21 only the least amount of force necessary should be</p> <p>22 used -- in other words, it shouldn't be</p> <p>23 disproportionate. He was familiarised with ACDT</p> <p>24 forms -- assessment care detention and teamwork forms</p> <p>25 used for monitoring detained persons at risk of</p> <p style="text-align: center;">Page 92</p>

<p>1 self-harm or of suicide -- and he was also familiarised 2 with the use of force forms. There were also incident 3 report forms which required completion when, for 4 instance, a DCO witnessed a fight on the wing. He had 5 a short period of shadowing more experienced officers, 6 and recalls receiving refresher training every six 7 months or every year.</p> <p>8 There were three incidents in particular that led to 9 Tulley contacting the BBC. The first was when, as an 10 ACO, he was in training with a DCO who was sitting in on 11 the training. The DCO had been suspended for the use of 12 excessive force on a detained person, but was on 13 a phased return to duty. The DCO told him about an 14 incident where he claimed a number of other staff 15 members had been relieved of their duties because, 16 during a night shift, they stood outside the cell of 17 a detained person under constant supervision on E wing 18 wearing George Michael masks and danced whilst staring 19 at the detained man. At the time, Tulley wasn't sure 20 whether to believe him, but he asked the DCO why the 21 officers had done this, and his words to Callum Tulley 22 were "to shit him up", which Tulley took to mean to 23 freak him out or to scare him. He heard the same story 24 from another ACO on another occasion, but Tulley never 25 saw any evidence to validate the account. If it was</p> <p style="text-align: center;">Page 93</p>	<p>1 had been inside this part of Brook House. The detained 2 man was completely naked, with around five staff members 3 present -- a mix of DCOs and DCMs -- who were laughing 4 and mocking him. He was shaking, he appeared scared, he 5 appeared distressed. Eventually, the detained person 6 was handcuffed before being ushered away by the Tascor 7 staff and put into the back of the van that 8 Callum Tulley was escorting. Tulley thinks the detained 9 person was given some boxer shorts to wear. He wasn't 10 able to see inside the Tascor van once the doors were 11 shut, but could only hear him kicking, screaming and 12 begging not to be taken away.</p> <p>13 Of course, Callum Tulley had no idea why the man was 14 naked and he didn't know whether there was a proper 15 reason for it. However, what he did know was that it 16 was wrong for staff to be laughing at him and he was 17 shocked by it. Tulley says, to use his words, the man 18 was humiliated and degraded by what was happening, which 19 was, as he puts it, obviously unacceptable. He didn't 20 consider reporting what he had witnessed. He had only 21 just started the job. He was 18 years of age. Although 22 he knew the behaviour was wrong, there were senior staff 23 around the detained man. He says he found the incident 24 extremely distressing and, when he got home that 25 evening, he made a note of what he had seen, and so he</p> <p style="text-align: center;">Page 95</p>
<p>1 true, it was, of course, a shocking account of abusive 2 behaviour by the officers.</p> <p>3 The second incident was, however, one he witnessed 4 himself while working as an ACO in what he calls the 5 solitary confinement block, also known as "the block". 6 He had been working in the gatehouse at the entrance to 7 Brook House with another ACO and was responsible for 8 admitting a Tascor transport van, which was the escort 9 company at the time, which was at Brook House for the 10 removal of a detained person held on E wing. When the 11 van arrived, his job was to buzz the van in, bring it 12 into a sterile area and check inside and underneath the 13 van using a mirror and take a note of the van's 14 registration number and its time of arrival. He then 15 released the second door. Because this detained man was 16 refusing to leave and was being held in the solitary 17 confinement block, the van had to drive around the 18 perimeter road to get the detained person from the rear 19 door of the block. Tulley walked alongside the van to 20 escort it to the block, because the Tascor staff did not 21 have keys, and he accompanied the Tascor staff into the 22 block to collect the detained man.</p> <p>23 When he entered the solitary confinement block with 24 the Tascor staff, the detained man was standing at his 25 cell or his room door. This was the first time Tulley</p> <p style="text-align: center;">Page 94</p>	<p>1 began to use a small black pocketbook to record 2 incidents at Brook House which he found distressing as 3 a way of processing what he had seen and also because he 4 felt he should record it.</p> <p>5 Despite this, he stayed on, first, he says, because 6 he didn't know if this was behaviour which was 7 indicative of systemic failings at Brook House which 8 allowed it to persist, and, second, some of the staff 9 members seemed good, compassionate people, and none of 10 the ACOs he had worked with seemed capable of that kind 11 of conduct. He also recalled that, during his training, 12 the need to treat detained persons humanely and with 13 respect was repeatedly emphasised.</p> <p>14 The third incident he recalls witnessing before 15 contacting the BBC occurred when he was working as 16 a DCO. An American Jewish detained person was put in 17 a head-hold for refusing to go back to his cell for the 18 8.55 pm lock-up. He was restrained by three officers at 19 the request of a DCM. The detained man wasn't a threat 20 to staff, says Tulley, and was merely upset about the 21 progress of his case, which is what he told staff at the 22 time. Tulley saw that he wasn't being threatening or 23 abusive towards staff. He had been sitting outside the 24 library simply refusing to go to his room for less than 25 15 minutes before he was restrained. The restraint</p> <p style="text-align: center;">Page 96</p>

<p>1 wasn't planned, but it was treated as a spontaneous 2 restraint, even though the detained man hadn't been 3 violent or self-harming. Tulley felt, therefore, that 4 the use of force was completely unnecessary. Staff 5 should have spent much more time trying to find a way of 6 convincing him to return to his room before engaging in 7 restraint. His perception, Tulley's perception, of 8 the incident was because this was at the end of 9 the shift, shortly before they were due to go home, 10 force was used because staff did not want their end of 11 shift to be delayed. If his perception was right, then 12 the rules regarding the use of force yielded to personal 13 convenience.</p> <p>14 Tulley's belief is that this behaviour reflected 15 a broader culture among certain Brook House staff in 16 which they showed apathy to vulnerable, disturbed or 17 distressed detained persons, and acted not in the 18 interest of their safety or welfare, but with the sole 19 intention of creating less work or inconvenience for 20 themselves. He also found disturbing the general 21 culture at Brook House. Some staff were apathetic, 22 hostile and sometimes aggressive towards detained 23 persons, which on occasions would manifest into verbal 24 abuse or excessive or unnecessary use of force. This 25 was also reflected in the conduct of DCMs who were</p> <p style="text-align: center;">Page 97</p>	<p>1 On 12 January 2016, Tulley emailed BBC's Panorama, 2 encouraged by watching a BBC Panorama documentary called 3 "Teenage Prison Abuse Exposed", in which G4S staff were 4 secretly filmed abusing teenagers at Medway Secure 5 Training Centre. This was first broadcast on 6 11 January 2016, the day before Callum Tulley emailed 7 the BBC. A BBC journalist, Guy Grandjean, contacted him 8 the next day, after which they remained in contact 9 through to the spring of 2016, when the primary point of 10 contact changed to Joe Plomin, who produced the Panorama 11 programme that has led to this inquiry. The BBC decided 12 to investigate Brook House and Callum Tulley was invited 13 to become an undercover operative. He began his 14 employment with the BBC on 6 March 2017 and, between 15 then and 23 April 2017, he received training. He 16 operated under principles that were set out for him in 17 his undercover role, which included a risk assessment, 18 legal guidelines and other guiding principles.</p> <p>19 To carry out the role, he was equipped with a secret 20 camera and microphone, which he wore during shifts, and 21 would turn on to record events and conversations. At 22 the end of a shift, he would meet with the Panorama 23 production team, and would then normally record a video 24 diary entry to camera, of which I have made mention 25 before. He would also hand over the camera with the</p> <p style="text-align: center;">Page 99</p>
<p>1 supposed to be in leadership roles. For example, one 2 DCM described detained persons to him "cunts" on several 3 occasions.</p> <p>4 He found there to be an "us and them" mentality 5 between Brook House staff and detained persons. He says 6 Brook House was severely understaffed, which is 7 a complaint repeated by other staff members, and staff 8 turnover was high. In his view, there was a culture of 9 abuse at Brook House among a significant minority of 10 officers and managers. He adds the majority of DCOs 11 weren't abusive; many were hard working, decent people, 12 trying to do their best in what he describes as 13 "a bleak, poorly staffed, highly charged and toxic 14 environment". However, officers who were deemed too 15 empathetic, helpful or kind to detained men were 16 themselves often marginalised, criticised or mocked.</p> <p>17 There was, he says, a visible hostility to raising 18 concerns. He called how the "Speak Out" posters, which 19 notified staff of a confidential whistleblowing line, if 20 ever they wanted to raise concerns, had the words 21 "snitches", "grass", and "don't be a rat" scrawled 22 across them. The IMB were also routinely described as 23 "snitches" by members of staff. Perhaps unsurprisingly, 24 Tulley never seriously considered blowing the whistle 25 internally within G4S.</p> <p style="text-align: center;">Page 98</p>	<p>1 day's footage to the production team. In the video 2 diary, he would summarise the shift and any particularly 3 notable events which had occurred. He recorded video 4 diaries on 38 days in total during the filming period, 5 which was from 19 April 2017 to 7 July 2017 inclusively. 6 The end of shift in the video diaries would be followed 7 by a debrief with the production team.</p> <p>8 His first day of successful filming at Brook House 9 was on 24 April. The last day of filming, and indeed 10 his last day at Brook House, was 6 July. From 24 April 11 to 6 July, Tulley worked 37 shifts at Brook House and 12 successfully undertook secret filming on 34 of those 13 shifts. There were equipment failures on certain days 14 of filming. Selections from the filming over the 15 three-and-a-half-month period were broadcast in the 16 Panorama programme which, as I said right at the start, 17 was aired on Monday, 4 September 2017.</p> <p>18 The three instances of mistreatment that led 19 Callum Tulley to contact the BBC did not, of course, 20 stand in isolation.</p> <p>21 MS HARRISON: Just before you start going into incidents 22 relating to this individual, we want to make a quick 23 message to the detainee, who is listening and watching 24 and doesn't want to hear recounting of the incidents 25 that he is the subject of. So if we could just have one</p> <p style="text-align: center;">Page 100</p>

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<p>1 moment, we will make sure, because of the three-minute 2 delay, that that is notified to him. 3 THE CHAIR: Understood. Thank you. 4 MR ALTMAN: If Ms Harrison had told me that earlier, I would 5 have made that announcement myself. 6 MS HARRISON: I'm very sorry. 7 MR ALTMAN: The Panorama programme showed other disturbing 8 incidents of mistreatment, such as the use of force, 9 whether sanctioned but disproportionate, or unsanctioned 10 use of force, albeit masquerading as the sanctioned use 11 of force, or just plain, deliberate acts of violence. 12 The programme also showed verbal abuse and the 13 mocking of detained men, some of whom had mental health 14 problems, or were at risk of self-harm and suicide or 15 were the subject of a medical emergency. Chair, it is 16 for you to decide whether any or all of this treatment 17 was in breach of article 3 of the European Convention 18 and, therefore, amounted to inhuman or degrading 19 treatment or punishment. 20 Callum Tulley lays emphasis on the fact that it was 21 only a minority of staff members who engaged in this 22 behaviour, but he felt strongly that the consistent and 23 undisguised nature of the abuse demonstrated a systemic 24 failing of the detention centre. Significantly, he says 25 that in the majority of examples he gives, members of</p> <p style="text-align: center;">Page 101</p>	<p>1 supervision, supervising a detained man on E wing, when 2 he heard noises coming from the far end of the wing, and 3 noticed that the door to D1527's room had been opened. 4 He walked over to it, where D1527 was. As he entered 5 the room, he saw a DCO by the name of Clayton Fraser in 6 the middle of the room, and a manager, 7 DCM Steve Loughton, standing by the inner wall by the 8 toilet area, looking at D1527 who was lying on the floor 9 with his head by the toilet and his legs towards the 10 inner part of the room. He was in a small space and 11 movement was restricted due to the position of 12 the toilet and the wall. 13 D1527 was attempting to self-strangulate, using 14 something which looked like cloth. Tulley left the room 15 to get help and he returned to the room to see that 16 Loughton was using a knife to cut the ligature away from 17 D1527's neck to stop him from strangling himself. D1527 18 was pulled from the area and placed on the bed to calm 19 down. At this point, no restraint had been used. 20 Tulley and Loughton were then joined by others. 21 D1527 stood up and went into a rage, making demands; 22 visibly upset and angry. He then sat back down and put 23 a phone battery into his mouth, attempting to swallow 24 it. DCM Nathan Ring arrived and he made several 25 derogatory comments directed at D1527, which Tulley says</p> <p style="text-align: center;">Page 103</p>
<p>1 staff who were otherwise well-behaving officers were 2 present during the mistreatment of detained men, which, 3 to him, underlay the lack of confidence staff had in 4 raising complaints about bad behaviour. 5 He also makes the important point that, although the 6 abuse of detained persons was consistent throughout his 7 time there, the staff members responsible for that abuse 8 changed over time. Some abusive members of staff left 9 Brook House, only for others to continue the abuse. In 10 his view, this demonstrated that the abuse at 11 Brook House could not be explained by a few bad apples 12 operating unbeknown to others, but it was the cultural 13 and systemic failings that gave rise to this behaviour, 14 which allowed it to go unchallenged and dissuaded 15 members of staff from raising concerns about it. As he 16 puts it, "detainees suffered as a consequence". 17 For now, chair, I am only going to deal with a few 18 events to which Callum Tulley bore witness. They all 19 featured in the Panorama programme. The first instance, 20 and beyond doubt the worst, is the restraint of D1527 on 21 25 April, the day after Callum Tulley's first successful 22 day of filming. 23 On that day, Tulley had been working his regular 24 shift of 8.15 am to 9.15 pm. During the latter part of 25 the shift, at around 7.30 pm, he was on constant</p> <p style="text-align: center;">Page 102</p>	<p>1 was normal behaviour for him. 2 The situation then calmed. D1527's door was shut 3 and locked, but, within a few moments, noise came from 4 D1527's room. Tulley returned, and this time was joined 5 by DCO Yan Paschali. In the same were Nathan Ring and 6 a nurse, Nurse Jo Buss, and joining them were DCOs 7 Charlie Francis, Clayton Fraser and another nurse. 8 Tulley asked Jo Buss what D1527's problem was. She 9 said, "He is an arse, basically". When Tulley asked 10 Paschali the same question, he replied, as Callum Tulley 11 recalled it, "Acting like a 3-year-old". Nathan Ring 12 commented D1527 would "start bouncing around like 13 a Duracell bunny", a clear reference to the battery 14 incident. 15 D1527 was on his back in a similar position to 16 before. Nathan Ring and Jo Buss entered the room, but 17 they left, leaving Tulley in the room to watch D1527 18 with Clayton Fraser. Tulley heard D1527 choking, 19 heaving and gasping for breath, with his hands around 20 his throat, trying to choke himself. Tulley asked him 21 to stop and tried pulling his hands away, and then 22 pulled him into the middle of the room, still telling 23 him to stop. He called for help. Fraser was behind him 24 but wasn't doing anything. DCO Francis arrived. Tulley 25 took hold of D1527's left arm and Francis took control</p> <p style="text-align: center;">Page 104</p>

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<p>1 of the right arm to stop him from continuing to choke 2 himself. Fraser took hold of his legs. At this stage, 3 D1527 was not resisting but he was in a state of 4 distress. Paschali then entered the room and knelt on 5 the floor with D1527's head between his knees. He leant 6 down towards his chest with his hands around the man's 7 throat and his thumbs on the front of the throat and 8 around the area of the Adam's apple. His fingers were 9 down the side and back of his neck.</p> <p>10 D1527 then became very agitated and then started to 11 resist. Tulley and Francis continued to hold his arms. 12 Paschali then exerted on D1527's airway what 13 Callum Tulley called a phenomenal amount of pressure. 14 He was now gasping for breath. Chillingly, Paschali 15 then said to D1527, in a quiet voice, "Don't fucking 16 move, you fucking piece of shit", adding, "I'm going to 17 put you to fucking sleep". Tulley saw D1527's eyes 18 bulging in his head, his face reddening, and he began to 19 froth at the mouth. So concerned was Callum Tulley that 20 he said to Paschali, "Yan, easy, easy". As Paschali 21 eased off the pressure, D1527 was struggling to 22 communicate and was gasping for breath. Tulley thought 23 that Paschali was going to kill him. Witnessing 24 a suicidal man being choked by a member of staff was, 25 says Tulley, extremely upsetting. Let me quote him. It</p> <p style="text-align: center;">Page 105</p>	<p>1 references, or the members of the public will. 0425 is 2 the date in reverse. 2017/0425. 00020 is the first 3 clip. For the evidence handler, the clip times which we 4 would like to play -- I note, chair, we have got ten 5 minutes, but if we can bear, perhaps, just for the rest 6 of this afternoon, to play this out, because it is about 7 18 minutes in length. It begins at 08:47 and ends at 8 26:33. So if we can start the clip at 08:47, please.</p> <p>9 THE CHAIR: Mr Altman, maybe if I can just confirm with you, 10 Ms Harrison, that you were able to contact --</p> <p>11 MS HARRISON: Yes, we were able to do that. We were having 12 difficulties in the room, so my instructing solicitor 13 went outside. Thank you very much.</p> <p>14 THE CHAIR: Thank you.</p> <p>15 MR ALTMAN: Here we are. Just before we start playing, we 16 can see the reference at the top left, "KENCOV1007". We 17 will find a series of that kind references. What 18 "KENCOV" stands for, I have no idea, maybe we will find 19 out, maybe we won't, but it is customarily joined by 20 four digits, in this case 1007. We will work our way 21 through to at least 1044, when we view or refer to 22 different clips throughout this inquiry. Right at the 23 bottom, we see the relevant clip, V2017, that's the year 24 date, 0425, month and day date, 00020, and the evidence 25 handler has kindly, at my request, started the counter</p> <p style="text-align: center;">Page 107</p>
<p>1 was, he said, "an abuse of power which endangered the 2 life of a detained man".</p> <p>3 The BBC footage shows these exchanges and Paschali's 4 actions just as described by Tulley. The footage shows 5 the incident continues with Francis ridiculing his 6 behaviour, calling him a "tool", an "idiot" and a "baby" 7 and saying that they were getting "bored" with his 8 behaviour. Staff members rolled D1527 onto his side and 9 eventually left the room. Tulley went to the toilet and 10 cried, and later there was a conversation between 11 Callum Tulley and Nurse Buss about whether to record 12 a restraint. There was a similar conversation between 13 Paschali and Callum Tulley. No use of force 14 documentation was completed in relation to this 15 incident.</p> <p>16 D1527 has requested that his face should not be 17 redacted by blurring or pixelation in the footage the 18 inquiry shows, albeit, as I indicated before, his name 19 will retain the cipher and the subtitles and the audio 20 track will remain redacted. However, the unredacted 21 footage, chair, is not ready yet to be shown, so for now 22 we shall only show the redacted footage. I am going to 23 ask for the footage to now be played, and to help the 24 evidence handler, we begin with <KENCOV1007>. The clip 25 number is V20170425, and we will all get used to these</p> <p style="text-align: center;">Page 106</p>	<p>1 at 08:47. What I am going to ask her to do is just to 2 play it. Before she does, we will see there is an 3 individual already in the footage. You can see his head 4 has been blurred out, and that is what we are going to 5 see. We will also see subtitles where ciphers, as 6 I have understood it, have been retained, as well as in 7 the audio track, redactions have been made. So we will 8 view that. As I say, it lasts very roughly about 9 18 minutes, I think.</p> <p>10 If we can just play that at normal speed. 11 (Video played)</p> <p>12 MR ALTMAN: Just pause it for a moment. I don't know if it 13 is RTS controlling the audio from behind the scenes, but 14 there is no audio that I can hear, or hardly any.</p> <p>15 Chair, I had rather hoped that this might have been 16 sorted out, but, if not, rather than ask the evidence 17 handler to try to sort this while we are all looking at 18 her, let's see if we can perhaps, if you wouldn't mind, 19 manage it and we will play it tomorrow.</p> <p>20 THE CHAIR: I think that makes sense. Thank you. We will 21 reconvene tomorrow at 10.00 am. 22 (3.54 am)</p> <p>23 (The hearing was adjourned to 24 Wednesday, 24 November 2021 at 10.00 am) 25</p> <p style="text-align: center;">Page 108</p>

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4	CHAIR	
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6	Opening statement by MR ALTMAN5	
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