Tuesday, 17 July 2018
(10.00 am)
Welcome and opening remarks by THE CHAIR
THE CHAIR: Good morning, everyone and welcome to Day 7 of the first substantive hearing of Children in Custodial Institutions investigation. Today we will hear further evidence from Mr Wood, the expert witness, from some of the institutions and read evidence from local authorities and finally from a representative of a user organisation.
Ms Hill, if there are no matters to deal with prior to hearing the witnesses, please proceed.
MS HILL: Thank you, chair, just a couple of matters by way of housekeeping. We will hear evidence today from G4S and we welcome their counsel, Mr Taussig, who sits to my right. Secondly, in terms of timetabling, you have kindly agreed to begin proceedings at 10.00 am today. Broadly, our intention was to hear, in accordance with the draft topics list, from Mr Wood first in relation to both Medway and Rainsbrook. I anticipate that that will take us to around 11.15, the time for the mid-morning break and then we will proceed to hear from the individual institutions.
Thank you.



MR ALAN WOOD (continued)
Examination by MS HILL
MS HILL: So, Mr Wood, you're going to give evidence in one group, if I can put it that way, about, firstly, Medway and then, secondly, about Rainsbrook. Can I ask you to pull up, please, your second/third report about Medway which lists the allegations that you looked at or the dates of them. It's INQ0001210 and it's internal page 18. It's your second/third report. If you can pull that up, please, and look at internal page 18.
No, it's not.
So we can scroll in, please, on the dates at the top and we can see that, as far as Medway is concerned, Mr Wood, you were asked to look at 11 allegations that spanned from May 2015 to December 2016. Is that right?
**A. That's correct, yes.**
Q. Just to give a little bit of a flavour of them, we can perhaps leave the list up, but I will just, perhaps, assist the panel in this way: looking at that list of dates, the allegation that related to October 2015 was an allegation, is this right, that a male detainee reported that another detainee had pulled a knife on him, tried to kiss him and to put his finger up his bottom, then hit him three or four times and this led to him having pain when going to the toilet and he



complained about not seeing the doctor and about this taking place in a classroom where there was no CCTV.
So that was the first allegation from October 2015?
**A. That's right, yes.**
Q. I have skipped over the main one. I'm just giving you some sense of them. There were also allegations made in relation to staff members. The allegation from 1 April 2016 was where a 16-year old detainee contacted the police, describing a male member of staff touching him in the groin area?
**A. That's correct, yes.**
Q. There were also allegations in relation to a female member of staff. The 6 April 2018 allegation was a suggestion that a female member of staff had an inappropriately close relationship with a trainee. Somebody had said, "He follows her around like a puppy. They sit on the sofa. It appears like something is occurring. It's uncomfortable to watch. It looked like a physical interaction", and there was a suggestion that another young person had tried to watch what was happening, I think this was in the kitchen area, and had been hit by a member of staff, apparently, it was thought, to avoid continuing to watch what was happening. Is that right?
**A. That's right, yes, that was the same member of staff who**



**actually assaulted the other young person.**
Q. Yes. There was then evidence or allegations in relation to a PlayStation having been found within Medway with pornographic material on it and, if I have understood it correctly, different suggestions about photographs of the children and a USB stick, I think, being part of this group of allegations. Can you just summarise what you had understood had happened there or what was alleged there?
**A. That's correct, yes. The female member of staff with the prior incident actually brought in the PlayStation to the unit. Another member of staff brought in a USB stick and on the USB stick was found pornography, which is used to be played on the PlayStation which is brought in by the member of staff. The incident in terms of pictures being taken of young people, that was another member of staff --**
Q. Yes.
**A. -- as well, so there are three interconnected issues there in terms of totally inappropriate relationships.**
Q. I think we will hear some evidence about police involvement about criminal proceedings, but I think just to try to summarise it broadly, some concerns about whether or not staff who were alleged to have been involved in these incidents were allowed to have

continued contact with the children. Is that right?
**A. That's right, yes.**
Q. There were various other allegations, just to give a flavour for it. The 16 April 2016 allegation was that a member of staff had wanked kids off, that was what was reported. 30 April, that a love bite had been given. I think a member of staff had overheard a child say he had been given a love bite on his chest and there were, I think, a range of allegations perhaps of a similar nature involving both members of staff and other children. Is that right?
**A. That's correct, yes.**
Q. In terms of the themes that you elicited from your review of the material, can we perhaps go to paragraph 6.1.1 which I think is further down this page, please, and is this right, that your first, perhaps overarching concern was of the nature of the allegations here that there were concerning themes, you say, of grooming, abusive and generally inappropriate behaviour by staff members and allied to that staff members being aware of what other staff members were doing but not reporting it?
**A. That's right, yes.**
Q. Is there anything else you want to say about that broad issue?



**A. I'll just say that in comment to a Ministry of Justice comment, that one member of staff did actually report the incident which is regarding the grooming-behaviour type behaviour. However, that was observed by other members of staff. It took one member of staff to, in effect, whistleblow. That's what actually happened.**
**My concern was that this appeared to be known behaviour. One relatively young new member of staff was a person who actually raised this issue and then took it further at that point, so that's what my main concern was.**
Q. I think you raised, later on in your report a particular example of this where staff members had failed to protect a child from being assaulted by other children and having his clothes removed?
**A. That's right, yes.**
Q. That was one example you gave. What was your particular concern about that?
**A. There are several, I suppose. One of the biggest elements of that was that the behaviour was observed by members of staff. There seemed to be little attempt to intervene. The comprehension of the events seemed to be people were having a joke with each other. The young person was stripped by a group of other young people, so, again, it's just in terms of what the expectations**



**were and what children could expect in terms of protection from members of staff.**
Q. You have made the point, I think, in your fifth report, paragraph 1.24 -- I don't think we need to bring it up -- that whistleblowing should be a required element in safeguarding training. But does it follow from what you're suggesting that the mere existence of a whistleblowing policy is not sufficient, that there needs to be more done to embed that culture of whistleblowing?
**A. That's correct, yes, I think whistleblowing is a difficult thing for any member of staff to do. It puts them in direct conflict with large numbers of other members of staff and potentially the organisation as well. The element of trust, in terms of what's going to happen next, in terms of the process, whistleblowing is there to highlight issues which haven't been dealt with in an appropriate way through other procedures. This particular member of staff, even though it didn't actually say it was whistleblowing in the record, my interpretation of it was in effect that's what she was having to do, to step beyond the management structure, to step beyond the members of staff she is working with to directly raise this issue.**
**I think from a safeguarding perspective, children**



**are reliant on adults to act in an appropriate way and to spot and identify and react in an appropriate way when they suspect or know harmful things are happening. So a child is reliant upon adults to follow what the process actually is, and I think, in terms of independent support for people who have to whistleblow, it was unclear in terms of what the process was here.**
**My recollection is that this member of staff decided to talk to someone else in the establishment but would only do so outside of the establishment.**
Q. In terms of the nature of the allegations, can I ask you this: compared to the different institutions that you had looked at -- you have looked at six different institutions and a series of allegations from each -- did these sort of allegations have any different quality to them, do you think?
**A. My perception is I was most surprised to see the range here in Medway. The fact in terms of the response to the allegations, as well, I was concerned about that as well as the allegations themselves.**
Q. The management response or the staff response or both?
**A. Both, really. I think for me, we talked earlier about the cultural element in terms of cultural expectations within establishments. The culture here, at that point, when I was looking at the records, seemed to be**

**an unhealthy balance between control and I think there was issues in terms of members of staff, how they perceived their role in terms of having to control children from a security-guard type point of view and that's contrasted to completely inappropriate relationships whereby professional boundaries weren't actually established. It seemed to be that there was no mechanism for those appropriate relationships to be found, reported on.**

**I was concerned that members of staff were observing this behaviour and one member of staff took the decision to step outside of that culture and say, "This is not an appropriate thing I've just witnessed". So it was very bound, I think, and I think for me, the concerns here reached a point whereby the nature of the relationship is at the core of other concerns we spoke about earlier.**

Q. As we established, if you perhaps just go to the beginning of the page here, the group of allegations that you looked at in relation to Medway spanned a relatively narrow chronological compass?

**A. That's right, yes.**

Q. From May of 2015 to December of 2016 and I think, to orientate the panel perhaps, that the Panorama programme about perhaps more physical-abuse type issues was



broadcast in January of 2016?

**A. That's right.**

Q. Is that what you understand?

**A. That's right.**

Q. Moving on then to some of the other discrete issues you identified with the institutional response by Medway at the time, I think you have pulled out a theme, again, about a lack of support to the children, or at least a lack of documented support to the children, who had made these disclosures. Can you help us with that, Mr Wood?

**A. That's right, yes. It's a repeated theme, I suppose, in terms of the fact that sometimes records were actually kept which described incidents or issues, but that was in contrast once again in terms of evidence of actual support to children and young people.**

**What was interesting, from a file reading point of view, was that the young person involved with a member of staff in the inappropriate relationship, the record would state that he stated he didn't want to make any formal complaint about that relationship or about that person, and that seemed to be accepted without an awareness of my interpretation, it was a grooming type relationship, through the behaviours exhibited, and there seemed to be little awareness of the emotional**



**connection which grooming actually is and how children and young people find it very difficult to break that emotional connection. That's the purpose of that behaviour.**

**So there's no record in terms of an awareness of those issues.**

**In terms of the record, in terms of actions regarding members of staff, there were clear records, again, in terms of what the process was, what happened, the meetings were dated, but that wasn't reflected in terms of the young people.**

Q. I think you have drawn out there perhaps another example, is this right, of that taking at face value of a child saying: I don't want make a complaint or don't want to pursue a complaint?

**A. Absolutely, I think, given the context of the concerns, I was surprised to see that was accepted and no further analysis was actually offered.**

Q. I think you've made the point that where the LADO had tried to give guidance in relation to strategy meeting actions, that wasn't reflected in a focus on the children's needs. Is that right?

**A. That's right, yes.**

Q. You have made a specific point, I think, that a clearer record of the work around children with disabilities



would have been helpful. Can you tell us a little bit more about that, Mr Wood?

**A. Absolutely, yes. I think in terms of the range of issues and needs exhibited by children and young people from a health perspective, understanding what additional needs are and how they may interact in terms of relationship building, in terms of behaviours, about needs in a wider spectrum, as well.**

**There seemed to be gaps there, so a full picture of the child's needs in terms of holistic needs wasn't always that clear. There were detailed records in terms of past histories of children and young people, which I read as part of this process, but, again, I think in terms of the forms being filled out in the correct way which highlighted what the known past experiences were, there's a gap in terms of the interpretation of that in terms of me being in Medway and how that may impact on the behaviours and needs going forward, as well.**

Q. I think you were asked some questions and you raised some issues about the nature of confidentiality in relation to some of the complaints. What was your overall view about that?

**A. It was difficult to track, I think, in terms of -- there's several examples we have given. I mean, the love bite incident/issue where a child was overheard**

**saying he'd got a love bite on his chest. The issue there really to be linked into confidentiality in terms of that there wasn't any sort of ability to track what's going to happen with it next, so there was a concern also which emerged from several examples, that's one of which, in terms of the connections between members of staff -- I think, for me, confidentiality on a couple of examples, the inappropriate relationship's a good one. Confidentiality seemed to be focused upon the staff keeping things confidential between themselves at the detriment of children and young people.**

Q. I think in relation to one of the allegations relating to May of 2016, you were given a summary of it that I think we can see at paragraph 11 of the letter of instruction, so it's INQ001733_007, please. Scroll in, please, on paragraph 11. You were asked about whether this reflected a summary of a different incident. This was the May 2016 one where a 17-year old boy made a complaint that a member of staff had touched his penis. In his initial complaint form the boy said he had not raised this before because, "'I was frightened to say anything and staff keep calling me a snitch'. The boy said he did not feel comfortable speaking about the matter to the LADO while within Medway. He accepted a production order so he could speak about it outside



the establishment, but it appears this was not effected."

If we go over the page:

"The LADO visited him again on 12 July 2016. The LADO asked staff to leave the room and go to the end of the corridor, which seemed to give him more confidence to speak. However, he did not wish to speak about a particular member of staff. He asked that that member of staff would not come back to work on his unit."

So I think you later agreed at 1.28 of your fifth report that that was another example of a child having concerns about confidentiality. Is that right?

**A. That's right, yes. If my recollection is correct on this, I think this also surprised the LADO. This young person was confident in terms of expressing what his views were, so it was a marked contrast in terms of his response to this incident.**

Q. All right. Moving on to how the allegations were actually responded to and investigated, I think you had made a point at paragraph 1.21 of your fifth report that there were issues around delay generally in responding to the allegations. Is that right?

**A. That's right, yes.**

Q. Then you were asked a series of questions and you have given several examples about the actual investigation



not following established procedures?

**A. Yes.**

Q. Help us with some examples about that, could you?

**A. There were issues in terms of the -- one incident about the "love bite" on the chest. There was no -- the procedures weren't followed in the correct way in terms of a physical mark or injury being seen. There's no health assessments of that, so evidence, if there was any evidence, actually lost as part of that issue.**

**The issues in terms of the relationship between the agency and the Children's Service department in terms of referrals, there are issues in terms for me of the LADO perspective also. To me, in terms of the other example we gave earlier about the group assault upon the young person whereby he was stripped, members of staff were actually present at that and the LADO perspective was that's a professional standards issue, not a safeguarding issue. So that goes back in terms of the concern element. So that was like a professional concern, not a safeguarding issue.**

Q. I think you thought that that was the wrong approach?

**A. Well, I couldn't really comprehend about why that decision was actually made at that point. So there's other -- that's one example of that, I suppose, really.**

**So there seemed to be a disconnection in terms of**



**the Children's Service department, the LADO and the establishment in terms of an inconsistent approach across a range of safeguarding issues.**

Q. I think you gave a few examples of this in your fifth report at paragraph 1.53. We can pull up, please, INQ001764, internal page 11, and scroll in, please, on paragraphs 1.3 through to 5. Here you pulled out some examples. The record linked to the 7 October 2015 allegation -- I think this might be the love bite allegation -- states:

"All necessary medical attention had been completed but there was no evidence of any records linked to this medical attention. It appeared that Child Protection Procedures were not followed in regards to this.

"Second, in relation to 13 May 2016, that allegation set of papers did not contain any evidence with regard to the alleged victim being medically examined, even though the young person did give her permission for medical information to be shared. The record also did not indicate that there was any action associated with the allegation that detainees were being left alone together."

Just bear with me a second, I think in relation to that allegation, just bear with me. I think that that was the allegation, or an allegation -- I don't think

I read this out -- that a male detainee kept touching a female detainee's bottom, grabbing her leg and her breasts and that she had bruises from it?
**A. That's right, yes.**
Q. You were concerned about how that had been investigated and then, third, the 13 June 2015 allegation does provide evidence that the response was largely an internal one. There is no evidence in the record examined of the two young people being interviewed in detail in regards to the allegation or of any other young people being interviewed in regard to the allegation. You say that in light of that you don't regard safeguarding procedures to have been properly followed. Is that right?
**A. That's correct, yes.**
Q. Just to try and bring that together, just bear with me a second. In fact I think that's all you say about that.
**A. Yes, that's right.**
Q. Thank you. So moving on, then, to the role of the local authority and an issue that we touched on yesterday, which I think is this, of the section 47 threshold. Just remind the panel what your concern was from the Medway material about that.
**A. It highlighted to me several interconnected issues,**



**I suppose, that the awareness of what the threshold actually was, there was some acknowledgment in terms of the threshold not being applied in a consistent manner. There are issues in terms of what significant harm actually was, so from a LADO perspective, that example earlier about the group assault, that wasn't seen as significant harm. So there isn't -- I mean, to me, there was clearly no consistent approach in terms of how the staff understood what safeguarding was, what the threshold was, what section 47 investigations were, about what risk was --**
Q. Just pause there for a second. If we perhaps bring up how you dealt with this in your report to assist the panel. It's INQ001764_008, it's your fifth report, Mr Wood and I think you, at 1.39 and onwards of that page, reminded the panel of the general threshold at 1.40, which is:
"A section 47 inquiry must always be commenced immediately when there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm in the form of physical, sexual emotional abuse or neglect."
I think you made the point yesterday that in your view the default position should be that if there is such an allegation or concern in custody, a section 47



inquiry should be undertaken. Is that right?
**A. That's right, yes.**
Q. At 1.39 I think you have made the point that Medway now sits alongside Feltham and Werrington as an institution where you were concerned that there were issues about the application of this in practice.
**A. That's right, yes.**
Q. Is that right?
**A. Yes.**
Q. You made the point, I think, in terms of outcomes. We will perhaps just deal with this while we're here. If you go to the next page, please, at the top of internal page 9 that in Medway approximately 27 per cent of the allegations were substantiated with 18 per cent having substantive police investigation and one being subject to a section 47 investigation. So in fact, across the piece of those four institutions that you looked at more closely in your fifth report, Medway has seem to have had the highest percentage of allegations substantiated, the highest percentage of police involvement and only one, but at least one, perhaps, section 47 investigation?
**A. My understanding of the records, yes, that is right.**
Q. You, I think, specifically compared the role of the LADO in Feltham and the role of the LADO at Medway at



paragraph 3 on internal page 12 of this report. While you were asked to compare the institutions, at the end of paragraph 3 you said that although section 47 investigations were a rarity across all types of institution, in comparison to Medway -- is this right? -- Feltham appears to have a low rate of substantive involvement from the LADO service?
**A. That's right, yes.**
Q. So you felt there was a more active LADO at Medway, but still not enough section 47s; is that right?
**A. That's correct, yes.**
Q. Now, dealing with the actual outcomes of these investigations, if I can try and pull these final threads together, please, I think you have already made the point that one of your concerns was that although the LADO was, perhaps, more involved at Medway than elsewhere, in relation to this one incident of children holding another child down, if you had been -- this was not a safeguarding matter but a professional conduct matter. Let's perhaps just bring up, please, INQ001210_018 and look at paragraph 6.1.3. This refers to the group assault upon a child. What was your concern about the role of the LADO here or is there anything you can add to what you have already said?
**A. I suppose all I'd add, really, I suppose, is it was**

**quite hard for me to understand why the decision was actually made. It wasn't a safeguarding issue. It was a clear assault on a child by a group of young people which was witnessed by members of staff. So there were professional issues in terms of standards, but actually the impact on the child was the most important theme for me and that seemed to be overwhelmed by the perception -- as you say, a member of staff who needed to given some advice on appropriate interactions.**

Q. I think this relates, does it, to an incident where three young people had held down a male detainee and removed all his clothes. All the young people were laughing, no staff had been supervising the area at the time, but the staff member who discovered it did not report it, and then you have concerns about the LADO's response to it; is that right?

**A. That's right, yes.**

Q. You have raised some themes in your fifth report at paragraph 1.25, perhaps we can bring that up, please, it's INQ001764, internal page 5 and scroll in, please, on 1.25 to 6. You were concerned about the members of staff about whom issues had been raised remaining on operational duties after allegations had been made. Help us with what your broad theme was about that?

**A. I think, for me, the choices and operational views in**



**terms of what the appropriate response was when allegations are made against members of staff did raise some issues to me in terms of -- the question mark for me was about, was this an operational choice being made, which is then not focused upon the needs of children and young people? So for me, serious allegations against members of staff, it's a protective factor for members of staff and also for children and young people for suspension or for alternative arrangements to be made.**

Q. Just to orientate this a little bit in the evidence when you've referred here to "staff B" and "staff C" at paragraph 1.25, if we go back, please, to the letter of instruction, it's INQ001733, internal page -- just bear with me a second. I think it's internal page 6. INQ001733, internal page 6, and scroll in on the second half of that page. I think staff member B was the member of staff who had admitted bringing in -- forgive me, downloading the pornographic material onto a USB stick in the STC, and staff C was a member of staff who was alleged to have brought in the USB with pornographic material?

**A. That's right.**

Q. It's those two I think you're referring to?

**A. That's correct, yes.**

Q. We can take that down, thank you.



You deal separately in your first report or your first report on the case studies with the concern that the staff member who had been involved in the relationship with the detainee had not been dismissed at the end of the process. If you look, please, at internal page 19 of your second/third report it's INQ001210, internal page 19, please and scroll in on paragraph 6.1.10 and help us with what your evidence was there. This is about the female member of staff who I think did face criminal proceedings for assault. They were not sustained, in a criminal trial?

**A. That's right.**

Q. And you were concerned about the response after the trial. Is that right?

**A. That's correct, yes. I think in terms of the fact that inappropriate grooming type behaviours were observed, an alleged physical assault did happen, I understand it did go to a criminal trial, so there was sufficient grounds to suspect it did happen in terms of the evidence threshold there.**

**I think for me, the view that -- this member of staff misunderstood what professional boundaries were, which I understand is the Ministry of Justice's view in terms of why this member of staff actually went back into full-time job there, and the issue that the culture**



**at the time meant that there may have been a misinterpretation of the professional relationships. I was still very surprised to see that as a reason why she's actually put back in that job.**

Q. I think we can see, I'm not sure we need to bring it up but HMP000402 is the Ministry of Justice response to your various points?

**A. Yes.**

Q. It is said at paragraph 21 of that document that there was a disciplinary hearing for this member of staff?

**A. Yes.**

Q. This member of staff was given a final written warning for 24 months. In light of the new culture which had prevailed at Medway in early 2016 -- forgive me, it was felt that the culture which had prevailed in early 2016 at Medway had caused her to misunderstand professional boundaries and I think, is what you're trying to say that you're not persuaded by that?

**A. I find it very hard to appreciate the fact that professional boundaries are so unclear in an establishment that a member of staff would in essence be told "That's not appropriate, but your job is still here". I find those two things very hard to actually to sort of line up with each other.**

Q. Can I perhaps ask for your view, then -- in fact, I will

bring this up, I'm sorry. It's HMP000402 and it's internal page 7, please. This is where you're asked to reflect on the MoJ's position on some of these allegations. Paragraph 21, I think, is the issue that we have just talked about, the female member of staff who was acquitted at trial and then received a written warning. But then scroll down, please, to 22 to 23, where the MoJ sets out its position in relation to the USB stick and PlayStation allegations.

Perhaps we can also just bring up the top of the following page at 24. Thank you. Paragraph 22, it said the MoJ comments that you may not have been able to elicit a full account of this incident. In fact, what the MoJ say happened is set out at 23:

"A PlayStation was discovered with uploaded pornography in June 2016. This had been brought into Medway several months earlier by the same member of staff referred to above."

That is the female member of staff?

**A. That's right.**

Q. "They had been given the PlayStation by another custody officer who had purchased it for a young person at their request. This was accepted practice at the time at Medway and the staff had not acted covertly. Upon the pornography being discovered, the matter was referred to



the police and has been the subject of a full criminal investigation. The pornography was found to have been uploaded to the PlayStation after it was brought into Medway. A different member of staff was identified as the main suspect in terms of having brought the pornography in on the USB stick and that member of staff was suspended and is currently subject to ongoing criminal proceedings for misconduct in a public office."

Then, at paragraph 24, I think you're asked to reflect on whether actually you do feel that there was insufficient action taken against the staff on this incident or, indeed, whether this characterisation of the fact changes your views.

**A. I suppose for me the key element to me was it was the same member of staff with the inappropriate relationship/grooming behaviour who brought in the computer, basically. So to me, there is a big potential sort of problem there.**

**I think in terms of the USB and a different member of staff uploading pornography to the USB and that getting into the hands of children and young people within the establishment, the record there does indicate that member of staff was suspended and subject to ongoing proceedings, which is the appropriate thing to do, obviously, but I suppose for me the fact that it was**



**the same member of staff who brought in the computer into the establishment, who enabled that, in essence to happen, wasn't really reflected in the first element of that.**

Q. So even if your views about the outcome of these particular issues are as you said, is there still a cultural concern here about these things seemingly happening at all?

**A. Well, it seemed to me that from what I've read this morning in terms of the response from Mr French that things have actually moved on a lot in Medway, which is very positive to see.**

**That doesn't actually, though, to me take away the issue that, from a cultural perspective, these very risky behaviours from members of staff in terms of their professional views, what their relationships are with children and young people, the impact on children and young people was very high. I don't know in terms of the record whether children and young people within this establishment had been exposed to sexual abuse or pornography prior to coming into custody, but the potential impact on children was very, very high.**

Q. Then I think my final question, if I may, on Medway: as we know, and we will hear quite a lot today about the transfer of responsibility away from G4S to HMPPS, we



will hear quite a bit about that later today and because of that change of management, you were asked to address whether or not there was a significant difference between early 2016 and later 2016, sort of straddling that period of a handover. If I can pull up, please, INQ001255_002 and scroll in, please, on 2.0 and onwards on that page.

I think we're going to hear, just to orientate this, from Mr French and perhaps also from Mr Petherick that it was March 2016 that it was decided the MoJ would take responsibility away from G4S. Medway was formally transferred back to the MoJ in July of 2016. Mr French is going to say, I think, that all G4S staff imposed at that time were to be transferred to the MoJ.

You were asked, effectively, to comment on this and is this right at 2.1 that you have said:

"The majority of documents were allegations prior to mid 2016. The themes, however, were relevant across the whole time period examined."

Is there anything else you want to say about that chronological split in July 2016 when the MoJ took over?

**A. I think in terms of the transition and points of transition being points of stress as well, I think what I would say is, really, that I am very pleased to see Mr French's statement in terms of how things have**

**improved and the cultural shift and the attempts to move things on in a very constructive way.**

**I think in terms of that period of time when the handover was actually happening, hopefully the impact on children and young people is going to be a very positive one.**

Q. Just for completeness, could I just bring up again INQ0001210_018. Of the 11 allegations you looked at, I think it is right, isn't it, to look at the dates and just note that three of them, one is in July 2016 --

**A. That's right.**

Q. -- one is in November and one is in December 2016?

**A. That's right.**

Q. Obviously these are the dates of the allegations made. You have been looking to some degree at the events that followed on from that?

**A. That's right, yes.**

Q. All right. Thank you. Chair, I will move on now, please, if I may, to deal quite separately now with a different institution with Rainsbrook, albeit the period of time that you have focused on for Rainsbrook, Mr Wood, again, is a period of time when G4S was running Rainsbrook. Is that right?

**A. That's right, yes.**

Q. In fact, if you look, please, at internal page 21 of



your second and third report -- so that's INQ001210_021, it's 18 allegations on page 21. 18 allegations you looked at for Rainsbrook and we can see that this does span a rather longer period from 2010 through to 2016. In fact, we can see, as we will hear later on today, that these were entirely, I think, at the time when G4S ran Rainsbrook. Is that right?

**A. That's correct, yes.**

Q. Just bear with me a second.

I think we will hear from Mr Jessup later today that Rainsbrook was transferred to MTC Novo and the commencement date for that contract was 5 May 2016, and so the final allegation you looked at was a matter of weeks before that handover --

**A. That's right, yes.**

Q. -- 18 April. Then just to try and put a little bit of flesh on to the bones, if I can put it that way, the sort of things that you looked at, by way of example, the 19 November 2010 allegation was that a male trainee had said that staff B inappropriately touched his genital area while carrying out searches and staff B said to another trainee "Get your knob out".

13 January 2011, a female trainee said a male officer was following her around, sitting next to her, calling her "Babes", following her into the shower,



"pushed it on and nipped me on the thumb", which I think might be a pain compliance technique, I'm not sure.

The 29 May allegation from 2011 was that staff B, a male member of staff, had restrained a female trainee and touched her inappropriately, tried to remove her top. She said, "I'm disgusted by this incident". There were various other allegations within the group that you looked at of inappropriate touching during restraint?

**A. That's right.**

Q. If I just try and summarise it that way.

**A. That's right.**

Q. One rather different allegation, 30 April 2013, a 14-year-old detainee had phoned Childline from Rainsbrook and said he was gay and people in the prison knew. "They think they can do what they want with him when he is in the shower. He dropped the soap and someone put their willy in his bum. He feels embarrassed and thinks people will laugh if they knew. The prison guards laughed at him when he told them. He is worried, if he writes a letter to his solicitor, the guards will read it and not pass it on."

There were also, though, more direct allegations involving members of staff. By way of example, the 23 April 2014 allegation was that a staff member had restrained a 16-year old boy. This was caught on CCTV.



The young person was sitting on the sofa. The staff member stood over him, put his knee on the young person's tummy and then threw a DVD -- he threw a DVD cover at the member of staff, who then tickled and bear hugged him. The young person ended up on all fours with the staff member squatting behind him, thrusting his hips towards the child?

**A. That's right, yes.**

Q. He said he was crying. The staff A member described himself as the dominant male. CCTV showed that the staff member had instigated the play fighting or restraint, I think it was described as?

**A. That's right.**

Q. That the young person was crying and said he had found this degrading. Is that right?

**A. That's right, yes.**

Q. I think there was one other allegation in July of 2014 where it was said that a staff member had said to a detainee: if you don't behave and calm down, "he would rape me" is what the child had reported.

**A. Yes.**

Q. And had said the same thing, I think, in both the written complaint and to his mother?

**A. That's right.**

Q. The LADO was concerned that no one had interviewed the

child after such a serious allegation had been made?
**A. That's correct, yes.**
Q. Just bear with me a second. There was an allegation about a female member of staff wanking off a trainee. That's 8 April 2014.
7 October 2014, about a female member of staff -- forgive me, I'm not sure actually if that is female or male. Just bear with me a second. Yes, a fairly new female member of staff had permitted him, a young person, to put his hand on her thigh, permitted other young people to touch her in a sexual way and that she had kissed detainees or at least one?
**A. That's right, yes.**
Q. So those were the sorts of allegations that you looked at. I think there were other allegations about sexual contact during searches. There was, I think, just finally, the 23 December one was where members of staff had permitted two young people to go into a bedroom together, knowing that one of the young people was going to defecate on the other young person's face?
**A. That's right, yes.**
Q. And that's something that I think ultimately did lead to dismissal proceedings?
**A. That's right, yes.**
Q. All right, so putting to one side, then, the nature of



the allegations you were asked to look at, help us then with the themes that you pulled out from your analysis of those allegations and scroll down, please, on that page to 7.1.1 and 2. What was your view of the record keeping here?
**A. I think in terms of -- there were some clear records in terms of what the process was, what the issues were, so it was easy to pick out those issues. So in terms of this area, it was quite easy to identify what the issue was, what the concerns were. But, again, in terms of a common theme across all institutions, and this one in particular, I suppose, the application of that form or the written form wasn't actually applied in terms of the needs of the child there.**
**There were also issues in terms of pre-existing awareness of issues prior to the child coming into the establishment. The example you gave a second ago in terms of the inappropriate touching which a member of staff permitted to take place, that young person who made that statement, it was known that he was sexually exploited by a female in the community, so there was little connection between those two things, little analysis of the meaning of relationships of this young person, the risks that would put him and/or members of staff in, as well.**



**So in terms of the knowledge held, that was substantial, but there's little evidence of that being applied in terms of the meaning for children and young people in this establishment.**
Q. So is this right, that it's similar to some of the other establishments to the extent that while the record keeping was better in terms of its form --
**A. Yes.**
Q. -- again, the content of it reflected a lack of understanding of children's backgrounds and the relationship between that and any later sexual abuse?
**A. That's right, yes. I think for me the purpose of the record is to enable safer care to take place for children and young people, for their needs to be established and met, for any risk to be identified, any work to be identified. So the record is actually the young person's record, in essence. That wasn't really reflected. And I suppose to me it sort of comes back to this care and control element about what the purpose of the job role actually is. So recording factual things is one thing, recording the meaning and the analysis of that is a different thing and there are quite large gaps there.**
Q. I think you generally felt there was a concern here that insufficient regard was had to the need to support the



child. I mean, that's the theme that you have identified elsewhere --
**A. That's right, yes.**
Q. -- but I think it's a theme you pull out here. Is that right?
**A. That's correct, yes.**
Q. You felt, I think, that there was a lack of understanding of why children may find it hard to disclose abuse, such as that allegation about the boy saying that someone's willy had been put in his bum in the shower and he was embarrassed to complain. You felt there was a lack of understanding of how children might feel in these situations; is that right?
**A. That's correct, yes. I think for a young person to disclose his sexual identity within a unit itself is really a big leap of faith for any child to do that, but for the response from members of staff, which is recorded, that they tended to sort of laugh at what he was saying, it was a very clear message to him that it wasn't going to be taken in a serious way.**
Q. You've made observations, I think, in your report. We can scroll down to 7.1.5, please, that, again, there seems to be a theme that you have pulled out of staff, perhaps, pre-judging the allegations that were made, thinking they might be malicious or false?

**A. Yes.**
Q. Is that fair?
**A. Yes, that is fair, yes.**
Q. You have made the point, I think, later on, that the culture should be around trying to encourage and enable children to report and not have children feel that they will be punished if they do. Is that right?
**A. That's correct, yes.**
Q. Just perhaps just let's pull up what you said about that in your fifth report. It's INQ001764, internal page 6. Scroll in, please, on the Rainsbrook section at the end.
You've reiterated your point:
"Insofar as children generally may face barriers to disclosing sexual abuse, the universal complications and pressures experienced by all children and young people in relation to barriers linked to disclosure are undoubtedly both magnified and concentrated within the secure estate. Being believed is directly associated with perceived and actual consequences of not being believed. In my opinion, it is not appropriate for a child or young person to feel, or be, punished if the allegation they have made is found to be not true, as the focus has to be maintained upon enabling disclosure of abuse in a child/young person in a focused manner given the barriers to disclosure that exist. If



an allegation has been proven not to be true, then it is much more appropriate for the child to be offered some direct work around communication, risk, trust and appropriate expressions of feelings."
Is that the point that you have made here?
**A. It is, yes. That is right. I think for me, the response when allegations have been found to be unsubstantiated or not true throughout the entirety of the investigation process, my experience would say that it's quite rare for children to lie completely about an allegation of sexual abuse in particular and it may be reflective of a previous experience which may be retriggered by restraint or by other behavioural issues, so the response to children and young people who are trying to communicate something by saying they have been alleged to be abused, my view is that behaviour and emotions are communicated in that way, so to be proactively working with children to enable them to understand what their issues are and why we move it forward in a positive way is really key. The difficulty, I think, here was, and in other establishments, that the approach wasn't a proactive one, wasn't a focused one upon children's needs, so the culture and the atmosphere wasn't actually helpful for that.**



Q. I think moving on then you again elicited in the Rainsbrook material, is this right, apparent disparity between the support given to the alleged victims and the support given to the alleged perpetrators. Is that right?
**A. That's correct, yes.**
Q. When those perpetrators were certainly staff anyway?
**A. That's right, yes. I think in terms of what the record would show, that's a very clear record in terms of the policy and processes of support given to members of staff, which obviously is the correct thing to do, but those weren't actually replicated in terms of the same amount of support or focus upon a child.**
Q. Can I pull up, please, what you have said about this INQ001210_024 and scroll in, please, on 7.1.19 and onwards.
You've come back again here, I think, to the serious allegation that staff members had facilitated an assault upon a young person or child:
"The documentation there in relation to the HR management process and so on was good. The same level of scrutiny, focus, energy and time does not appear to have been repeated in relation to supporting the alleged victim of the assault and the needs of the perpetrators", you say.



Is that right?
**A. That's right.**
Q. Then you repeat that theme, I think, at 7.1.21 where the allegation was made against members of staff. Again, there was a focus on support of the staff:
"This was apparent at all points in regards to the allegation process. There was a stark contrast to the approach taken in terms of what was offered to the children."
Is that how you have dealt with it?
**A. That's correct, yes. The records I have examined are clearly defined in terms of the processes around members of staff but there's little evidence in terms of records and support for children and young people.**
Q. Moving on then, you've also pulled out some concerns, I think, about how the investigations were actually carried out and the quality of those investigations. If I can go, please, within your fifth report to paragraph 1.56, so that's INQ001764, internal page 11 and scroll in perhaps there on the Rainsbrook section.
First of all, you deal with the 7 July 2014 allegation. Just by way of reminder -- just bear with me a second. This was one where the child or the young person had said in a written complaint, and to his mother, a member of staff had said "If you don't behave

and calm down, I will rape you"?
**A. Yes.**
Q. What were your concerns about how that was investigated?
**A. I think in terms of the response to that, the fact that it was -- no further action was taken in regard to that. I think it was quite difficult to see how that process was actually mapped out. So the young person did allege this to happen. It's written down, as well. The mother of the young person was concerned. The young person was obviously concerned, as well. But there seems to be very little evidence of any formal investigative process associated with that.**
Q. It looks as if the LADO had had involvement --
**A. Yes.**
Q. -- and the LADO had said there was a disappointment no one had interviewed the child. The LADO had said it seemed poor practice to make a "no further action" outcome?
**A. That's right, yes.**
Q. But I think you were concerned that that -- is that perhaps where it ended?
**A. It is, yes. That's right.**
Q. I think there was some suggestion of a lack of CCTV or witnesses --
**A. Yes, that's right, yeah.**



Q. -- but it's not very clear. Then in relation to the next allegation, the 8 August 2014 allegation -- just bear with me a second. I will just remind the panel which one that is. That's an allegation that a trainee or a young person told staff that he had seen a fairly new member of staff, a female member of staff wank off another trainee?
**A. Mm.**
Q. What was your concern about how that was investigated?
**A. It followed a very similar issue, I suppose, in terms of it not being clear what the process actually was, so who was spoken to about it, what the processes were associated with that, whether it was deemed to be sufficient to reach the thresholds for any sort of level of investigation.**
**So, again, I think it was in terms of a statement has been made of a concerning issue but tracking that in terms of what the decision-making processes was is quite difficult to pick out.**
Q. Just go back, please, can we just scroll in on 1.57. It's INQ001764 -- that's it. Paragraph 1.57. Again, there was a lack of clarity or a lack of evidence about interviews being undertaken in regard to the young person, or the alleged perpetrator. The agency seemed to have responded to the alleged victim in terms of



giving a message that may in essence shut down further allegations being made, and to appear to consider the positive reputation of the alleged perpetrator as being evidence of the allegation being false?
**A. That's right, yes.**
Q. Overall, mapped against the Working Together guidelines, you felt that that did not comply with those expectations; is that right?
**A. That's correct, yes.**
Q. Just go back, please, in this report to internal page 8. Again, I think, at 1.39 and onwards you have included Rainsbrook in the group where you felt that there were insufficient section 47 inquiries taking place. Is that right?
**A. That's correct, yes.**
Q. Then, in terms of the final outcomes of these investigations, can we go back, please, to your second/third report and to internal 7.1.17, so that's INQ001210 and it's internal page 24, please. Help the panel with how you feel the children and young people were told of the outcome of these investigations?
**A. The comment I make, I suppose, there, really, is that the forms used, the letters used, were probably what they were asked to use in terms of what the proper process was but the content and the style of the written**



**information to children didn't actually -- in my experience, anyway, in my opinion, didn't actually meet what a child would actually want to read, so it's very clearly defined in terms of what the process was, but not written in a way whereby a child or young person may know what the issues actually were. So the process was actually followed in the correct way in either writing to a child or informing the child what the outcome of any investigation or issue was, but the style of writing to a child wasn't that helpful.**
Q. You made an observation, I think, in your fifth report, please, INQ001764, internal page 9, that overall your understanding of the figures in relation to Rainsbrook was that 17 per cent of the allegations appear to be substantiated. 11 per cent had police involvement so perhaps more than some of the other institutions?
**A. Yes.**
Q. But still no section 47 investigations; is that right?
**A. That's my understanding of the record, yes.**
Q. Then just bear with me a second. Finally on this, can I go to 8.1.4 of your second/third report which we will find at INQ001210. Let me see. Just bear with me a second. I may need to deal with this later with you.
Yes, I'm not sure, actually, that I can deal with that now.

I will, though, finally, please, ask you the same approach, ask you for your views on this issue of the 2016 timing, again. Can we pull up, please, INQ001255_002. That is in relation to the significance of timing around Rainsbrook. As you now, I think, understand, all those allegations took place just before the handover to MTC Novo. Do you have any further observations to make about that?

**A. Nothing further to add, I suppose. I suppose, just to reiterate in terms of the period of change, that's all I'd say, really.**

Q. What would you like to say about that? I think you have been provided with MTC Novo's evidence that we will hear later today. Is there anything that you wish to say about that?

**A. I think in terms of the changes, again, in terms of the structural changes, the approach changes, it's positive to see that there is some recognition of the culture prior to the change, what's appropriate. So, again, I think in terms of the opportunity to move forward in a constructive way is there.**

Q. But just trying to pull these threads together as this will be something that we come back to today, the sort of things that you have seen in this material, is it fair to assume that it takes time for some of these



cultural issues to change?

**A. I think any organisational change in a culture is extremely difficult to do because culture is embedded throughout the entire span of the structure, so the individual behaviours of members of staff is a cultural issue, as well as how the organisation's actually led and the support structures around that. So it encompasses every single aspect.**

**I think, for me, from a leadership point of view, examples have got to come from the top, really, in terms of what people expect, how you communicate with children, how you engage with children. The focus from a safeguarding perspective needs to be embedded all the way through the culture, but actually physically changing people's attitudes and behaviours is difficult, unless clear expectations are part of the contract.**

MS HILL: Thank you.

Chair, those are all the questions I have for Mr Wood on Medway and Rainsbrook unless you and the panel have any questions?

THE CHAIR: No, thank you, Mr Wood. Not at present.

MS HILL: Thank you, Mr Wood.

**A. Thank you.**

MS HILL: Chair, in light of the time, perhaps we might just use a little bit of time until 11.15 to begin



Mr Petherick's evidence.

Can I call, please, Jerry Petherick.

MR JERRY PETHERICK (sworn)

Examination by MS HILL

MS HILL: Thank you very much. Take a seat, please, you're Jerry Petherick; is that right?

**A. That's right, yes.**

Q. You're the current managing director of G4S Custodial and Detention Services. Is that right?

**A. It is.**

Q. You have been employed by G4S since July 2008?

**A. Yes. Yes.**

Q. You're here to provide evidence about the systems for safeguarding that are in place. You're going to talk, I think, about the Secure Training Centre that you still operate, that G4S still operates, at Oakhill, but you're also here to talk about the institutional response to the allegations that Mr Wood has reviewed from Medway and Rainsbrook. Is that correct?

**A. It is correct.**

Q. You've also provided some general evidence about staff attrition rates about diversity statistics and about policies and so on that we will come to, because you're here partly to also explain G4S's role in the events that we have heard about at Medway and Rainsbrook and



then the handover of both of those institutions. Is that right?

**A. Yes.**

Q. Your evidence is set out, Mr Petherick, in two statements, the first dated 19 June, chair, which I will formally adduce, please. It's G4S000007, and the second statement that is at G4S000127, that is dated 12 July 2018. With your permission, chair, I will formally adduce those.

Can I deal, first of all, perhaps, just before the break, Mr Petherick, with the issues around Medway, all right? I'd like to try and take these in chronological order, if I may.

I think, for completeness, can we just bring up briefly the 2014 inspection report from Ofsted that I think we may have looked at before. It's INQ001481 and if we can go, please, to internal page 7 of that document. Just to help orientate the panel in terms of the history here, this inspection took place in September 2014 and, at that point -- 16 to 26 September 2014 -- the overall effectiveness of Medway was good with some outstanding features. Do you see that?

**A. I do.**

Q. We can see by looking, then, forward in the chronology

that by the time of the Panorama programme in early 2016, there was then a much greater scrutiny of the institution that led to the HM Inspector's visit in January of 2016 and we will pull up, please, the note that Professor Hardwick went through when he gave his evidence at INQ001478_001.

Is this right, Mr Petherick, that the prompt for this visit by the Chief Inspector had been the showing of the Panorama programme. Is that your understanding?

**A. I can only assume that's correct because it should be stated that I only took over responsibility for Medway on 1 June 2016, so I don't have direct knowledge of this period of time.**

Q. But you're doing the best you can. I think you've provided some documents around this time. But you're aware, I think, are you, of the nature of what was shown on the Panorama programme?

**A. I am.**

Q. Just, perhaps, looking through the note from the Chief Inspector, Professor Hardwick, what is said is that, at that time -- one can scroll in on paragraph 1 -- there were 45 young men and ten young women in residence, it wasn't quite at capacity, it had a capacity of 74, that children were spoken to, as were managers and the director of Medway Children's Services.



If you scroll in, please, on paragraph 5:

"In addition to positive comments, a small number of young people described some staff using insulting, aggressive or racist language, not always challenging poor behaviour and feeling unsafe in areas not covered by CCTV. In addition, some young people told us the high turnover of staff led to new staff not fully understanding or managing behaviour on the residential units. A high turnover of custody staff had been a feature of Medway in the last 12 months. This is reported as in the region of 50 per cent of the basic rate custody staff. Two young people expressed concern about restraint and although senior managers were aware of both incidents, inspectors requested an assurance that normal safeguarding procedures were followed. G4S were asked for a report on an incident of restraint that a young person had said had happened to them when in Rainsbrook. The concerns raised with us by a small number of children [go to the next paragraph, please, paragraph 6] are consistent with the evidence presented by the BBC investigation, which showed targeted bullying of vulnerable boys by a small number of staff in addition to the conditioning of new staff. There was also evidence in the BBC programme that a large group of staff must have been aware of unacceptable practice but



did not challenge or report this behaviour."

Pulling the chronology together, I think what happened here is that the Chief Inspector made some immediate recommendations, or in fact approved the immediate actions that were being taken, but said at paragraph 8, there were significant concerns about the centre:

"It is clear from the BBC footage that a number of staff must have been aware of unacceptable behaviour and the practice of falsifying Use of Force records that had gone unreported."

And, again, had been expressing concerns about the high staff turnover rate, areas of a lack of CCTV and a broad theme that managerial oversight had failed to protect the young people from harm.

Just to perhaps fill in a little bit of detail on this, can I ask for the Medway Improvement Board report to be brought up. That's MED000003, internal page 9. Scroll in, please, on 1.6 to 1.8. This summarises, I think, Mr Petherick, does it, just so that the panel can understand this, what the Panorama programme had showed? On 11 January 2016, this was a 30-minute documentary undercover. The reporting of the incident had led to the suspension of seven staff members including one assistant, 14 leaders and two managers.



The reporter had acquired a job as a custody manager for G4S. The programme showed what appeared to be unnecessary and disproportionate use of physical restraint including footage of a young boy, Billy, being restrained by four members of staff while a senior staff member appeared to place his hand on his windpipe, potentially making it difficult for the child to breathe. Viewers witnessed a staff member boasting about harming a 14-year old boy when he stabbed him in the leg with a fork. Throughout the programme, frightening and intimidating behaviour and language were seen to be used by staff. Staff were also heard discussing how they falsified records because of organisational pressure to ensure G4S was not penalised or fined for breaching the terms of the contract.

So these key documents provide, is this right, Mr Petherick, part of the background to G4S no longer running Medway. Is that right?

**A. They provide part of the background. It should be noted that during this time the contracts for both Medway and Rainsbrook were being recompeted. My understanding is that the contract for Medway was extended until the end of June 2016, when the company withdrew from that contract and HMPPS took over that contract.**

Q. G4S, I think, was involved in a dialogue with the Medway

Improvement Board, is that right, about an action plan which you have provided and I think, is this correct, that the action plan that G4S drafted in negotiations with the MoJ was not actually finalised because the transfer of responsibility superseded it? Is that what you have said?

**A. That's my understanding, yes.**

Q. You've provided that draft improvement plan. It is, though, I think pertinent for the panel to be sighted upon some key parts, please, of the Medway Improvement Board report. Panel, I will just take you through these parts briefly to fully understand the detail that this went into and then we can perhaps have our break.

It's MED000003, internal page 6, please, and if we scroll in, please, on (4) and onwards, the executive summary here I think gives a flavour for what the board found. (4), the board found problems that members found alarming, as set out in the interim advice that had been given on 2 March. Just putting a hand in that for a moment, later on in the report, at 1.4 -- we don't need to bring it up but it's internal page 8 -- interim advice had been given on 2 March which highlighted concerns including that G4S staff -- well, whether or not G4S staff had had sufficient understanding of safeguarding issues. The interim findings included



concerns about leadership, about the relationship between G4S and YJB and about the YJB's understanding of the terms of the contract and expressed concern about previous whistleblowing cases.

But going back to the final executive summary, please, these were the themes that the board brought out about G4S's running of the centre. (6), there were blurred lines of accountability and an ambiguous management structure and, I think, Mr Petherick, you've provided some information about how the structure of STCs are run now that I will come to; is that right?

**A. That's correct.**

Q. The safeguarding measures were insufficient and outdated. There was too much emphasis on control and contract compliance, not enough on the best interests and mental well-being of the trainees; not convinced that organisations that were scrutinising the STC were coordinated; a history of concerns being raised by whistleblowers and former members of staff; concerns about behaviour management and restrictive physical interventions; and concern about how the YJB monitor role was working.

Then you perhaps can help with this. (12):

"The board feels that while the revised improvement plan received from G4S on 15 March takes on board



earlier feedback from the board, it does not go far enough. In particular, it does not take into account the board's concerns about handover and continuity if, following the announcement of their intention to sell the contract, responsibility for managing the STC moves from G4S. Regardless of who manages Medway, changes in culture, leadership and staff approaches are needed. For these reasons, the improvement plan needs to incorporate effective mechanisms for continuity of improvement, assessment of impact of improvements and a timetable for handover."

Does that reflect some of the discussions between the MoJ and the G4S about the detail of the action plan?

**A. I can only assume so from my reading of the improvement plan. It was very much a dynamic plan as I would expect it to be and the comments noted on the document would show the interaction between the two organisations and I think that's entirely appropriate because this is a process of improvement and, in my 38 years of managing custodial establishments, that is the appropriate way forward, that there is a dynamic approach to such work.**

MS HILL: Let's just bring up briefly -- in fact, no, chair, we can perhaps take a break there. It's perhaps an appropriate moment for our break. I will come back to these issues after the break. Thank you, chair.



THE CHAIR: Thank you. We will return at 11.35 am.

(11.20 am)

(A short break)

(11.35 am)

MS HILL: Thank you very much, chair.

Mr Petherick, in fairness to you I should have perhaps gone through your background a little bit more before starting your evidence, just to help the panel understand the context here. You are the current managing director of G4S. Is that right?

**A. Of G4S Custodial and Detention Services, yes.**

Q. Sorry, that's my shorthand. But in terms of your direct involvement with these particular institutions, is this right, that it was in June of 2016 that you took on responsibility for the Secure Training Centres and it was at around that time, shortly after that, that Medway was transferred to NOMS in July of 2016?

**A. Yes. Technically, 30 June. So I had Medway in my stable for 30 days, I didn't have Rainsbrook in my stable at all. My responsibility is very much for the prisons we operate, the immigration centres we operate, the community contracts in South Wales that we deliver and now, obviously, Secure Training Centre.**

Q. And so your evidence, when you give information about systems and so on, if I have understood it correctly, is

often based on your understanding of Oakhill. That's one institution that you know a bit better; is that right?

**A. That's correct, yes.**

Q. Because Oakhill is the STC within England that G4S have retained the contract for?

**A. That's correct, and obviously I have had experience of the unit we have at Parc Prison ever since --**

Q. In Wales?

**A. In Wales. Ever since I have operated with G4S.**

Q. But as far as any wider evidence is concerned, you're doing the best you can to assist us because you are the witness who has been put up effectively by G4S?

**A. Correct.**

Q. So you are the only G4S witness we have?

**A. Yes.**

Q. So when I am going through some of the matters of background, we understand the limits to which you can assist us, but you are nevertheless here to try and answer some questions --

**A. Absolutely.**

Q. -- on behalf of G4S?

**A. Absolutely.**

Q. All right. I wanted, if I may, please, to bring up some particular parts of the Medway Improvement Board because



this may well be a document that the panel considers it fit to read in full. I have drawn up the executive summary already. Can I perhaps bring up for the panel MED000003, please, internal page 5?

The panel can see from that page that the structure of the Medway Improvement Board report was to look at several key themes. We have been through the executive summary already, but the board looked at issues around leadership, culture and management. Issues around safety, issues around behaviour management and the use of restraint, issues around the contract management and monitoring and then it looked in detail, Mr Petherick, at the G4S improvement plan.

Just perhaps if I can take the panel through this, just to flag a few pages, please, the section on leadership culture and management begins at internal page 15 and the panel can see that that chapter runs for several pages. The conclusions are at internal page 23, please, paragraph 2.57 and onwards.

The conclusions of the board were that the culture at Medway appeared to be one of containment and contract compliance rather than support and rehabilitation. There was a lack of clarity about who was accountable for young people's outcomes. The focus appeared to be on contractual compliance as opposed to the well being



of the children. There was insufficient oversight of the work of the operational staff, in particular DOMs. You can help us, Mr Petherick, with what that stands for, I think?

**A. It was the daily something managers, I forget what the O stands for.**

Q. Operational?

**A. Operational managers, thank you, a role that no longer exists at Oakhill.**

Q. But they were the people with frontline responsibility for the children. Is that right?

**A. Yes, they were the minute-to-minute managers of what was happening in the establishment.**

Q. So at a management level, but very much at the frontline?

**A. I would typify it as being first-line managers or, in the wider custodial estate, commonly called orderly officers or something similar to that, who would be the point of reference for any frontline member of staff to go to in the first instance and who would respond to any incident.**

Q. I think the concern of the board was that there had been insufficient oversight for those staff and provision for their ongoing training and development was inadequate, particularly in relation to behaving ethically:



"Staff recruitment, along with initial and ongoing training, does not adequately prepare new staff for their role, in particular understanding the range of special needs young people present with.

"This has led to an unacceptably high attrition rate for staff, which has in turn left the STCs exposed, having to manage the consequences of both staff shortages and inexperienced staff and leaders on-site."

On that final topic, Mr Petherick, I think you have provided some attrition rates for the panel and you might be able to help us in understanding how they are translated. I think you've given us some exhibits which show the attrition rates. Perhaps we can bring up, please, your JP2, which is at G4S000008_002. You may need to help me a little bit in understanding them, Mr Petherick, but I have done my best.

What you have given, I think, are some tables that show attrition by post in 2014 and then you've given similar figures for 2015 as well.

Help us with what the 31.9 per cent overall attrition percentage for 2014 tells us.

**A. That would be the overall percentage of staff who have left during that calendar year. Sometimes it's analysed on a calendar year, sometimes on a rolling 12-month basis. As you will see from the documents here, there's**

**a large range of attrition. The training centre assistant, the third row up from the bottom, is perhaps the most pivotal in this context because that would be the frontline staff.**

Q. I see. Help us, then, with the difference, if you can, between the figure on internal page 2 and the figure on internal page 5. There is a different chart for attrition in 2014, giving a 20 per cent figure and I'm not immediately sure, it may well be me, for which forgive me, in understanding why there is a 20 per cent figure there. Is that just a different way of calculating it or is that about a different --

**A. I can only assume it's a different --**

Q. -- pool of data?

**A. -- or a different time period. I really --**

Q. Well it's headed in 2014.

**A. 2014.**

Q. Can you help me with that? Just bear with me a second?

**A. I've got one here, attrition for 2014, one for attrition by 2015.**

Q. Yes. Just bear with me a second. It may be the answer is, in paragraph 77 of your witness statement, that JP2 includes statistics for both Medway and Rainsbrook, but it's not immediately clear. Either way, it looks, does it, as if the attrition rate is somewhere between



31 per cent in 2014 and 20 per cent -- that's perhaps a different institution. Is that right? It's still a pretty high attrition rate?

**A. Still a high attrition rate. It's quite likely that 20 per cent would be Rainsbrook, which, by my understanding, had a lower attrition rate than Medway, not least because of the geographical area in which they're situated, because all of these attrition rates are inevitably contributed to by a number of factors: local geography; local economy; the state of the establishment; pay rates, and so forth. So it's a complex mix that brings into the overall attrition.**

Q. Let's just try and bottom it out as far as Medway is concerned. If we're right that the first pages of JP2 are about Medway, we see on internal page 2 a 31 per cent attrition rate in 2014. On internal page 3, a 28 per cent attrition rate in 2015. Is that right?

**A. Yes.**

Q. Just bear with me a second. In fact, that's not right. I'm sorry. You need to look at a different exhibit which provides it in a slightly clearer way, because I think you've given us the same information in a further exhibit. We have attrition statistics specifically for Medway in your exhibit JP5. Let's try



that, please. It's G4S001275. It looks like this does label the institutions, forgive me. So the Medway figures are internal 15 of that. This is perhaps a better document. I think this indicates -- it's G4S000127, 15 -- in fact, that the figures for 2014 for Medway were 20.26 per cent. If we can try and bring that one up, it's G4S000127, internal 15. Thank you, just taking this, if I may, this is labelled Medway so that makes it a bit clearer, so it's a 20.26 per cent in 2014, but then scrolling through, please, to internal page 18, it goes up in 2015 to 40.42 per cent. Is that the figure for 2015?

**A. That's as it shows here, yes.**

Q. Then if we scroll through to internal page 21, it goes down in 2016 to 26.42, so those are the overall figures for the Medway attrition rates. Is that right?

**A. That's how it reads here, yes.**

Q. What one can see by breakdown is that if one looks at the night assistant, for example, 14 of the 14 had left. 24 of the 78 training centre assistants had left. These figures, though, may reflect the changes in ownership of the -- forgive me, changes in management of the institution. Is that right?

**A. Yes, it might, it might --**

Q. But going back, please, to the 2015 figures at internal



page 18, those figures, that figure of 40.42 per cent attrition is prior to the handover from G4S back to the MoJ, isn't it?

**A. It is. It's entirely likely and we have seen it elsewhere that as new competition happened for a contract, people become uncertain and we can see an increase in attrition in the south. Again, it depends largely on the geography of the area and the availability of alternative employment.**

Q. The G4S report, though, by the Medway Improvement Board was concerned, though, about the impact that this attrition rate was having on children, wasn't it?

**A. Yes, and that's a valid concern, because, where attrition does increase, obviously it -- you lose experienced staff very often, you -- quite often, there's a time lag between a member of staff leaving and the necessary recruitment, vetting and training procedures in terms of replacement. So that's a valid concern.**

Q. Then if I can go back, please, to the next part of the Medway Improvement Board, the themes around safety were brought out, please, in section 3. That's MED000003_028. This is the chapter generally on safety and the panel can perhaps read this, but certain themes were brought out around, for example, if one scrolls in

on 3.3, the YJB monitor did not have unfettered access to the CCTV. There was evidence that G4S was manipulating what the monitor had access to. Going over the page, please, there were concerns expressed -- just trying to summarise it -- about, although there was in existence a series of policies for safeguarding around a range of topics, 3.9 and 10 indicate that a number of people had expressed concerns about how the policies were actually being applied at the STC, particularly around the cultural change needed to provide a better balance between care and control. That was a view expressed, it seems, by both the Children's Commissioner and the Chief Inspector of Prisons.

There were various points made in the safety chapter about accounts given by children of their concerns about safety. Perhaps the panel can go, now, to internal 43, please, which is where the MIB reached its conclusions about safety.

It felt there needed to be a review of the contract terms that refer to suicide and self-harm, to make sure that they support the overall safety of young people rather than focusing on penalties on the contractor that distracted from the safety and well-being of the child, formal mechanisms to ensure the child's voice was heard:



"The policy for whistleblowing and acting on information received from whistleblowers needs to be redeveloped in both the YJB and within the STC and it must ensure that whistleblowers feel supported and listened to. All whistleblowing communication must be made available to the governing board on a monthly basis. The role of the Barnardo's advocate needs to be reexamined as the board feels it is currently not fit for purpose."

Just pausing there, if the panel are just taken back briefly, please, to internal page 40, there was, Mr Petherick, is this right, a quite lengthy section where the board expressed a range of concerns about whistleblowing within Medway?

**A. Yes, and it's something that we have concentrated a lot of effort on and I have spoken with representatives of the Jill Dando Institute to take learning worldwide in terms of the operation of whistleblowing lines and processes. I think it's important to make sure that such processes, staff do feel (a) are available -- we publicise it that any whistleblowing allegation is treated with utmost seriousness and, indeed, with confidentiality, because now within the company any whistleblowing complaint comes up not through the managerial line, but outside, through our legal lines**



**and goes straight to the Group Ethics Committee which is the most senior committee and are investigated outside the operational line in the majority of cases.**

**So I am unaware exactly of how many whistleblowing allegations are being looked at at any one time, and I think that's important because it maintains the proper distance from the operational line and that can give staff the confidence that these things are taken seriously, are investigated separately and any necessary actions taken.**

**What I do know is the seriousness that this is dealt with and primarily in the post-Medway period.**

Q. I think you have been made aware, Mr Petherick, of the evidence that Sharron Rollinson will give tomorrow where she had expressed concerns within Medway at around this time. Do you, as an organisation, accept the concerns expressed by the MIB about how whistleblowers have been dealt with at a previous point in Medway's existence?

**A. I think some of the issue has to be understanding the definition of whistleblowing, because I think all of us would want staff to feel confident that they can raise any concern with their line manager or, indeed, with the director of the establishment or, indeed, in my case, with myself as I'm walking around or am available. There needs to be a separate whistleblowing system that**



**enables people, if they aren't confident and satisfied, to take that concern outside of the operational line. So I do think we always need to be very careful about the definition of whistleblowing processes. I see some of those as normal managerial developments. It's my job, as the leader of my business, to actually inculcate the culture whereby staff feel they can raise concerns appropriately, have them dealt with appropriately. I would love them to be dealt with by the most junior possible management there. I know only too well from my experience that that isn't always the case for a number of reasons and that's why I encourage people to contact directors, myself, and my chief operating officer to ensure that.**

**Over and above that, there has to be a separate whistleblowing process and, as I say, we have spent quite a time talking to reps from the Jill Dando Institute to take their learning from around the world and look at the NHS processes in this country in particular, which they commend as a model of good experience. We talk to the NHS representatives and we're looking to bring in whistleblowing champions in each establishment to actually make people feel more confident about the processes.**

Q. Have those processes fed into the new whistleblowing

policy that we find at G4S000128, that's dated May of 2017?

**A. Yes and increasingly because we're still developing some of these. I have in my team an assurance manager who reports direct to me, who is responsible for actually making sure that I know what's happening in establishments without any risk of dilution as it moves up the management chain. We're looking currently at expanding that team and I'm looking at utilising a former prisoner to actually become one of those team members, because we know from our experience that I will talk to prisoners or to detainees or to trainees in a certain way based on my own experience in both the public and the private sector.**

**I know only too well from that experience that very often people in detention, whatever their age, whatever the type of detention, will talk more readily with someone who's travelled the same road, and so we have involved this individual in some of the work we're doing already and we have benefitted hugely from it. I see a role for people such as that with that experience in this area, as well, because what I have learnt throughout my career is that I have to triangulate information. I obviously visit my establishments, I walk around, I talk to staff and prisoners or**



**detainees who are the children at Oakhill, as I walk around. I form an opinion. I want to check that opinion against other people's visiting, the inspectorate, the data that comes in, because, back to the Jill Dando Institute, one of the messages they gave me very loud and very long is: make sure you're analysing the data, look at patterns. And that's what increasingly we're doing. So I need to triangulate what I see, what I hear and, subjectively, what I feel as I go around.**

Q. Can I ask you this, then: the policy that you have provided for whistleblowing in operation now within G4S, what, can you explain to the panel, is the way in which this is being embedded within frontline staff to make sure or give the panel some reassurance that the situation that we have heard about happening at Medway where members of staff did not report obvious misconduct is less likely to happen again within G4S STCs?

**A. Sure. I think a number of ways. We have to talk about it and actually really drive the message, "This is confidential". We obviously train people to it. We put up posters, we remind people of the system. Recently, we gave out credit-card-sized plastic credit cards with the whistleblowing line -- the speakout line, as we call it -- with the available numbers on how to do it.**



**I have done a secret shopper approach to this on two occasions, now, to test my experience when I actually access the phone number and see how I was treated by the people listening to the complaint and I gained from that.**

Q. We can perhaps just scroll down within the whistleblowing policy to see a reference to your speakout hotline on internal page 3 and is this a new initiative, Mr Petherick the G4S speakout line?

**A. My memory is that it's been refreshed and renewed post-Medway. What I do know is that the -- and as you would expect, the group legal team and the risk team absolutely follow this through and I get questioned on various cases and so forth, so I know how assiduous a process it is.**

**It's my job, as part of my leadership role, to make sure that I talk about those experiences not in the detail because that's a breach of confidentiality, but about the process and to reassure both staff individually and staff associations and unions that this is a process that is followed with the utmost seriousness and it's one of the issues that I get questioned on in my sessions with my manager and, indeed, I have talked right up to Ashley Almanza, the chief executive of G4S, on a global level about the**



**processes. So do I think it's seriously taken? Absolutely, I do. I have felt the pains of it on occasion.**

Q. Can I just adduce, please, some remaining parts of the themes pulled out by the Medway Improvement Board. Can we go back, please, to the beginning of the section that deals with behaviour restraint? Just for the panel's note, section 4 of the report is MED000003, internal 44. I think the MIB was concerned that there be a general review carried out by the MoJ, if you go to internal page 50, their conclusion in relation to restraint issues I think went beyond Medway. There were various points made in detail about the nature of how physical restraint had been used at Medway, but the conclusions of the board clearly went beyond that to look at whether or not restraint across the STC estate should be reviewed.

I just for completeness adduce, please, the following section 5 of the report dealt with the way that the contract was being managed. The conclusions of that are at internal 56. There was a concern about the conflict between the YJB monitoring role and ensuring actual compliance and monitoring safeguarding and then, Mr Petherick, perhaps more pertinently for you, the G4S improvement plan section begins at internal 58 and the

panel can see the way in which that was dealt with by the board over several pages, ending, please, on internal page 61, where essentially the G4S were required by the MoJ, I think, to clarify certain parts of the action plan it had reached. Is that right?

**A. That's correct.**

Q. For completeness, please, you have provided the action plan in one iteration of it, in any event, at G4S000132, internal page 1 and onwards, please.

The panel can see that this internal action plan -- go into the next page, please -- included a range of measures, but just by way of example, the first overview, "Working together to collectively change the view and culture at Medway".

If you scroll down, please, to the next page, there was a particular action around ensuring staff had the appropriate level of safeguarding training. Is that right?

**A. That's correct as it's shown here, yes.**

Q. And then various other actions the panel can review and look at but they included things that may bear on the panel's issues, such as, on internal page 5, at the top of page 10, "Treatment of young people as individuals and with respect and dignity", those were the sort of things that the action plan was looking to implement; is



that right?

**A. Yes.**

Q. Then a final logistical point, perhaps, on internal page 10, "Implement wider use of body-worn cameras and CCTV". Is that right?

**A. Yes.**

Q. Although I think your evidence has been that this plan was never formally finalised with the MoJ, would you nevertheless expect that these are the sort of themes that were progressed by whoever took over the institution from G4S?

**A. Absolutely.**

Q. We will perhaps come with the later witnesses to look at the reports about Medway from August 2016 and onwards, but are you aware, although it's slightly after the handover, that the first report from the Ofsted and Chief Inspector and CQC in August 2016 was based on a visit in June of 2016 when I think you were in charge?

**A. Yes.**

Q. And that concluded that, overall, the institution was inadequate across its general effectiveness and several of the subcategories. Is that right?

**A. That's correct. My recollection is that the visit took place in mid June.**

Q. For completeness, the panel can pull up, please, or have



pulled up, please, INQ001479_001 and they can see then that this report which straddles the handover period effectively concluded that Rainsbrook was overall inadequate; the safety of young people was inadequate; promoting positive behaviour was inadequate; the care of young people was inadequate; some elements were good; the effectiveness of leaders and management was inadequate; and the achievement of young people required improvement.

So from your point of view, that was effectively how Medway was handed over to the MoJ. Is that a fair summary?

**A. By definition, really, that's the Ofsted view of how Medway was at that period of time. I absolutely don't have the experience to confirm or otherwise that, but I take the inspectorate's objective views on that.**

Q. For the panel's purposes, perhaps particularly internal page 7, please, where the inspectorate concluded that the safety of children at Medway was overall inadequate and made various observations about how child protection matters were not dealt with adequately that ran over several pages. I'm not asking you to go through them, Mr Petherick, but are you broadly saying that the inspector's findings speak for themselves, you don't want to comment on them in particular?



**A. I don't think I can comment on them, because I don't have the knowledge to do so.**

Q. Can I perhaps move, then, to some of the detail of what Mr Wood fleshed out about Medway and then I will come back, please, to Rainsbrook. If we look, please, at your second witness statement and find page G4S001272, you have responded to the themes that Mr Wood has pulled out at the foot of this page and on to the next page and, essentially, is this right: you agree with some of the observations he makes?

**A. Yes.**

Q. I think. You have made the point, I think, at 6.1.1, that on occasion Mr Wood's report reads as if the allegations were all found to be substantiated. I think you make the point that that isn't the case. Some were found not to be substantiated?

**A. Correct.**

Q. But if you look, please, at the detail of, otherwise, what you have said, apart from that, 6.1.4, you agree that there should have been more evidence in that allegation to show if appropriate support had been given to the child?

**A. I think reading the reports I was very aware that I had a bundle of documents and I had to form a judgment on that bundle of documents. What I didn't have was access**

**to any other documentation. That might have shown the support, et cetera for the young people, but based on the information that I could see, I would have looked for more evidence, yes.**

Q. I think you have made the point at your next paragraph that in responding to Mr Wood, 6.1.7 you fully accept that staff must support signs of any grooming activities, they're trained and instructed to do so and, on the basis that that did not apparently happen in some elements at Medway, that would be a concern, would it?

**A. Unequivocally, yes, because staff are trained, that's their role, that's their responsibility and I would expect them to do so. I recognise the difficulties, but that's my expectation without any equivocation whatsoever.**

Q. You agree with his comments in relation to point 11, point 12 and point 13, in particular that the medical examination referred to in 11 should have taken place?

**A. Yes.**

Q. I think you make the point that the decision not to dismiss the female member of staff who had had a criminal trial was not taken by G4S, that was later on in the chronology; is that right?

**A. That's correct.**

Q. I think you have been made aware, Mr Petherick, this is



limits of your evidence, is this right, that at around the same time, I think slightly earlier, Rainsbrook was handed over from G4S to MTC Novo. Is that correct?

**A. No, I question the term "handed over".**

Q. Forgive me, that's probably my ignorance.

**A. No, no, not at all. There was a competition for both Rainsbrook and Medway organised by the MoJ, normal contractual competition. As I recall from general conversation, one of the rules of the competition was that any company would not win more than one of the two establishments. As I recall, we bid for both. Our bid for Rainsbrook wasn't successful and so MTC Novo took over that contract.**

**As I recall, our initial bid for Medway was successful, but then subsequently we withdrew from that contract.**

Q. So is your understanding that the transfer, if I can call it that way, perhaps, more neutrally, of responsibility for Rainsbrook from G4S to MTC Novo was simply the consequence of a rebid?

**A. That's correct.**

Q. I think we see at paragraph 34 of your first witness statement that G4S sold its Children's Services business in 2016, but you retained responsibility, I think, for Oakhill?



finally on Medway, please, that the inquiry's prevalence analysis suggests that there were over 30 allegations of sexual abuse at Medway in 2016. At the time, we understand that there were around 29 children resident there. Do you want to offer a comment on that?

**A. I don't know that the 29 was a constant number or anything like that. I'd have to have access of necessary data on that.**

Q. Just pause there. In fact, I think we also heard earlier that there was a higher number in early 2016. The Chief Inspector's report had 55, so maybe the number does fluctuate, but our analysis shows over 30 allegations in that calendar year, I think. Do you want to offer a view on that, relative to those numbers?

**A. On those -- on the base data, it would seem a high percentage.**

Q. I think our evidence has been that -- just bear with me a second. I think our understanding had been that there was either nil or very few of those reported to the Chief Inspectors during the surveys, but those are the internal figures that we have gathered. Do you understand that?

**A. Yes.**

Q. Thank you. I'd like to move on now, if I may, to the issues around Rainsbrook and, again, understanding the



**A. Yes.**

Q. Can you just help us understand that?

**A. Sure. My predecessor was the managing director for Children's Services which had two business streams under the one role. One was for the children's homes. The other was for the Secure Training Centres, so the company sold the children's home business. My predecessor left the company with that business on a TUPE transfer and it's at that time, where we retained Oakhill, that it became my responsibility.**

Q. I see. You say, as far as you're aware, paragraph 38 of your statement, all the relevant personnel who worked at Medway and Rainsbrook are no longer employed by G4S.

**A. That's true. There are a couple of managers who were at Rainsbrook, who, in the normal process of careers and employment, did transfer to Oakhill in managerial positions, one of whom became the director of Oakhill.**

Q. But apart from that, is it your understanding that the staff who were at Medway and Rainsbrook TUPE transferred to the MoJ in Medway's case and to MTC Novo in Rainsbrook's case?

**A. That's my understanding --**

Q. I see.

**A. -- in great part. I mean, there's always some individuals.**

Q. Just before we come to some points of detail on Rainsbrook, these are perhaps some generic issues about both of the establishments. Rainsbrook is a mixed-sex facility. Is that right?
**A. Correct.**
Q. Oakhill, you make the point that there are single rooms only at Oakhill?
**A. Yes.**
Q. Help us with how you say the change in the cohort of trainees at both these establishments has had an impact?
**A. I think it's not just an impact at these centres but across the estate. I think you've already heard about the welcome decline in the number of children in custody from 3,000 to circa 900.**
**What we have seen is, as a natural occurrence from that, a concentration of more challenging, more seriously charged individuals. To put some context to that, yesterday I looked at our data for Oakhill where we were caring for 59 youngsters. The breakdown from that is ten of those youngsters are there either on remand or convicted of murder, one of attempted murder, three of manslaughter, 26 for offences of serious violence such as robbery or a section 18 GBH, two of rape, one of terrorism charges.**
**So that is a very different picture to the**



**population statistics of the cohort of several years ago. It's a natural consequence, and obviously it's our job, alongside every other institution, to make sure that we care for them appropriately, that we, I think, are all aware, as operators, about that change in cohort and the complexities and the challenges that it brings with it.**
Q. Just one other generic point before I come to the detail on Rainsbrook. You've made the point in your witness statement that recruitment is always managed locally by each of these institutions, that all the staff are recruited, trained and vetted in line with the contract, the standard of recruitment that G4S uses is the same as in public prisons. Is that right?
**A. At least the same. In our instance, the company requires under the vetting we do, because there's the MoJ vetting that goes on, the company also vets separately and our requirement is a ten-year history of employment. I think that's different to the MoJ standard which stands at five years but that's a belief, I can't say definitively. So in some ways, if I'm accurate in that, our vetting is even more onerous.**
Q. I will take this briefly, if I may. In terms of the period of time when Rainsbrook was run by G4S, we have provided, I think, you with several of the reports that



were provided by the inspectorates. Can I ask you, please, just to pull up INQ001568_001, which is the February 2015 report. I will try and take this relatively shortly.
That found, did it, that Rainsbrook overall, if one looks at internal page 4, was inadequate in terms of its ability to meet the children's needs. Is that right?
**A. That's as defined here, yes.**
Q. And that, as far as this panel is concerned, safety at internal page 13 was also judged to be inadequate. Is that right?
**A. Yes.**
Q. And that there were various incidents described in the report there that the panel can read of internal inappropriate behaviour, matters not being referred to the local safeguarding services as quickly as they should have done, matters not being referred to the national MMPR panel and things of that nature. All under the heading of safety that perhaps bear on the issues that this panel is looking at. Is that right?
**A. That's as reported, absolutely.**
Q. There was insufficient supervision of staff was another theme pulled out after paragraph 44 and a range of issues that led to that overall finding of a lack of safety for the children. Is that right?



**A. Yes, as written here.**
Q. If you go, please, now to internal page INQ001781 -- forgive me -- 001, that's a report that I think for my learned friends inadvertently made its way into the Medway section of the topics list, but clearly is about Rainsbrook. This is a report that was commissioned by G4S, as far as I understand it; is that right?
**A. Yes.**
Q. Chair, you may remember we heard some evidence that Professor Hardwick alluded to last week about G4S commissioning a report in response to an Ofsted report?
**A. Well, I think --**
Q. Sorry, forgive me, our understanding, and please tell me if this is wrong, is that this report, carried out on the basis of an inspection or review by Sir Martin Narey in July 2015 followed on from that report that I have just gone to. Is that right?
**A. That's my understanding and I think it's important to recognise that after a long period of very positive Ofsted inspections and then a negative one, I, you know, as a custodial manager, would look at that -- and I come back to the comments I made earlier about the need to triangulate issues very often -- and so, where I have a concern about one of my establishments, I will often get someone from outside the establishment, I use**

**another former chief executive of the National Offender Management Services to do this, to tell me his views about where that establishment is at, because I need to triangulate the information to check it against my own assessment and to determine the way forward as to how to improve the situation.**

Q. I think in fairness you see at the beginning of that page that the context was that Rainsbrook had had some historically positive reports. It says:

"This was the 15th inspection. All previous inspection ratings had been 'good' or 'outstanding'. The verdict on this occasion was 'inadequate'. The effect of the judgment on the establishment staff has been profound."

I think there had been some negative press reporting with the Chief Inspector of Prisons telling Radio 5 that there was a concern about what had been found, that he had been personally shocked by what he had seen. The chief executive of The Howard League had said that this was the worst report on a prison she had ever seen because it is a catalogue of abusive practices that have been inflicted on young children who have no escape.

Sir Martin Narey's review looked at similar themes to those brought out by the Ofsted review such as safety and education and things of that nature. If the panel



go through to the end of that report at internal page 11 -- forgive me, internal page 10, pulling the threads together, he seemed to form the view that the inspectorates had been unduly influenced by some particular incidents in 2014 that were serious but that he felt needed to be looked at in a wider context. Is that a sort of fair summary?

**A. Yes.**

Q. He said towards the end of the next page:

"There needs to be discussion with the staff about why there had been so many dismissals. There was a particular concern about this degrading assault and the shocking failure in care that it represented. But my test [he says] in visiting places of custody is how I would feel if my son or daughter were incarcerated there. In Rainsbrook's case, I would consider him or her to be safe and to be generally well treated. That's not to suggest the inspectorate's recommendations should not be accepted, but I don't believe the inadequacies that the improvements address means that Rainsbrook is or was an unsafe place for children."

Is that right?

**A. That's what Sir Martin said, yes, and I know that the test he refers to there about his own son/daughter being safe in the establishment is a frequent one that he**



**applies to such visits from his experience.**

Q. Just to complete this part of the evidence, please, because this does still deal with the period of time when G4S was running Rainsbrook, the next report in December 2015 gave it a "requires improvement" category overall. I don't need to bring it up, but for completeness that's INQ001572. Safety also required improvement in that, which is a better grade, isn't it --

**A. Correct.**

Q. -- it is improved? And the same was true -- I think the last report before Medway was taken over by Rainsbrook -- forgive me, Rainsbrook was taken over by MTC Novo was from a March 2016 inspection. That's INQ001570 and, again, it was a "requires improvement overall" grade and a "requires improvement" on safety. Is that right?

**A. That's my understanding, yes.**

Q. In fact, I think we will hear that that grade has carried over into 2017 perhaps after your period of responsibility.

Now, as far as some of the other institutions are concerned -- well, in fact, no, before we do that, let me just deal with the points of detail about the case studies from Rainsbrook that you've responded to. Can



I deal, please, with what you say in your second witness statement. It's G4S000127 internal page 3, where you've responded here, Mr Petherick, to what Mr Wood has said about Rainsbrook.

**A. Yes.**

Q. I think, again, it's a similar sort of theme, is it, that from the material you have seen, you agree that the documentation did not suggest as much support for the child as you might have liked to have seen, but you would question whether there was more material that might indicate that. Is that right?

**A. Yes, it is, because I had no access to the entire documentation.**

Q. Where he's made observations about the malicious description of allegations, you say, if you scroll in, please, on 7.1.5 and 7:

"There should not have been mention of the outcome of previous allegations in incident report. I would state my surprise at the seemingly official 'malicious' classification for the outcome. That is a term that has not been used for many years in custodial settings. I find it inappropriate."

And you've agreed with other observations that he has made. Is that right?

**A. Yes, I have to say, when I read the term "malicious",**

**I was staggered by it, because I worked for 23 years in the public sector prisons and there used to be a category of "false and malicious allegations" which was removed a couple of decades ago, so it really struck me as very strange to see that classification in -- with this age group in particular.**

Q. I think, finally, over the page, you've agreed with the remainder of Mr Wood's observations in particular that the letter was not written in a style that was appropriate for children to be told of the outcome of an allegation. That doesn't apply just to Rainsbrook, but I think you're saying that what you saw from Rainsbrook wasn't as clear as you would like but it isn't an isolated example of that sort of thing?

**A. No, it isn't, and it isn't, I should say, purely constrained to G4S letters of that type. I was quite -- it was quite noticeable that some letters from local authorities, et cetera, to children were written in a language that, really, I felt was very adult, and I'd like to think that someone sat down alongside and interpreted the language. The risk is that didn't happen and so the language does need to be far more child-centric, in my view.**

Q. Finally on this, if we scroll in, please, at section 8 of this report or this letter or statement, even, is



what it is, sorry. You respond to Mr Wood's report at section 8 and you say, insofar as he has made some general comments:

"While I might disagree with some of the nuances applied by Mr Wood to the various elements of section 8" -- and that's, I think, section 8 in his earlier report -- "I find very little to disagree with in the thrust of his statements."

**A. That's correct.**

Q. Just for the panel's note, the section 8 that you're referring to is where he pulls out those generic themes that we took him to early yesterday morning and it's the section that begins at INQ001210_025?

**A. Correct.**

Q. Just before we leave Rainsbrook entirely, can I just do the best I can with those attrition figures for Rainsbrook, which you will find at G4S000127, internal 5 -- sorry, forgive me, internal 6 is the actual start of the figures, and they show, do they, for Rainsbrook in 2014, attrition of 31.9 per cent?

**A. Yes.**

Q. Over the page at internal page 9, 28 per cent in 2015?

**A. Yes.**

Q. And then into internal page 12, 17.47 per cent in 2016?

**A. Yes.**



Q. I think you said, Mr Petherick, that your overall impression is that attrition was less of an issue at Rainsbrook than it was at Medway. Is that right?

**A. That was my impression. And I have known -- because one of my prison establishments is adjacent to Rainsbrook. I have known periods of high attrition from there and periods of low attrition, but in general, I would say that Medway had a higher attrition rate because of the geography.**

Q. The figures in 2014 and 2015, though, do show 31 per cent and 28 per cent, which is a pretty high figure, isn't it?

**A. Yes, yes.**

Q. I think, as a practitioner, you would understand, would you, the potential impact of those high attrition rates on the quality of the ability to build a positive relationship with children and things like that?

**A. There is a very strong correlation between high attrition rates and those kinds of difficulties. As I say, the period of recruitment training, vetting, and so forth, can cause short-term problems, but it's that constant change. I think all individuals, but particularly children, need to have some kind of constant figure in their lives to actually build the confidence and so forth.**



Q. I'd like, in my final few questions for you, please, Mr Petherick, to focus on the future in terms of G4S's responsibility, but is there anything else about Medway or Rainsbrook that you feel I need to pull out on your evidence? You have given quite a bit of material, but I hope I have done fairness or justice to it.

**A. Absolutely, thank you.**

Q. In terms of STCs in England, then, the only one that is run by G4S now is Oakhill; is that right?

**A. That's right.**

Q. And in fairness, for the panel to perhaps understand where Oakhill sits at the moment, you've helpfully provided -- let me just pull it up to formally adduce it, please -- G4S000130, the, I think, relatively new safeguarding policy for Oakhill that is from March 2017 --

**A. Yes, so that's the --**

Q. -- updated in June?

**A. Correct, that's the latest revision.**

Q. That, the panel can look at in due course, but that's a fairly lengthy 30-something-page policy that sets out a range of elements as required.

This is a G4S policy, but is it locally applied to Oakhill or is it your generic safeguarding children policy?

**A. No, that is the Oakhill policy, so we have driven those improvements. We have taken cognisance of the Working Together format. I know there is a further revision with the 2018 Working Together document. We have worked with the Milton Keynes Safeguarding Board because a lot of my experience says that the important relationships are the local relationships as opposed to nationally imposed relationships, because very often it's about the chemistry, it's about how professionals work together with the interests of the child. So we have driven it very heavily in that way.**

Q. The Ofsted report on Oakhill from March of last year, please, is at INQ001790 this is of course the joint Ofsted/CQC/HMIP report. That gave Oakhill an overall category of requiring improvement, but gave it one "inadequate" finding for promoting positive behaviour, one "good" finding for the achievement of young people but otherwise "required improvement" was the categorisation given to it. Is that right?

**A. Yes, that is right and I think recognition in the introduction about the involvement of Oakhill in the wider custodial and detention services business stream was having some benefits with some progress. Lots of work to do was identified at that time.**

Q. I think if one looks, please, in the internal page 3,



the panel can see that it refers, again, at the top to this institution also having significant challenges because of difficulties in recruiting and retaining staff. Staffing pressures have been heightened by rising levels of violence within the centre. A new director had been appointed halfway through last year. The centre was transferred to the management of the custodial and detention arm of the parent company. Since that time, there has been purposeful change and improvement from a low base and I think, as you say -- the panel can read the remainder of this -- there were certain recommendations made, but broadly it was a "requires improvement" overall rather than "inadequate" overall?

**A. Yes.**

Q. The panel may wish to look at internal page 7 which is the section specifically around safety and, again, the overall finding for that was "requires improvement".

Perhaps in particular, please, if we can go to internal page 8, paragraphs 10 and 11 where child protection issues were dealt with. The centre is undertaking a review of its child protection policy and procedure. The head of safeguarding had recognised a shortfall in referrals but was in the process of updating the documents ready for discussion and



agreement with the local board. 83 per cent had been trained in safeguarding -- forgive me, in the centre's own Child Protection Procedures as at the end of 2016 and recent child protection matters had been managed appropriately. So that was the findings in 2017, in the middle of 2017.

However, just to complete, please, this part of the evidence, if one looks at INQ001789 and brings up a further report by the inspectorates, by November of 2017 the categorisation for Oakhill was "inadequate" in terms of both its overall effectiveness and safety; is that right?

**A. That's correct and it followed what had been a very challenging year or part of a year. I think largely generated by an assault on 17 March of that year, whereby one of my colleagues was very badly assaulted by five trainees, still the matter of ongoing criminal action and that undoubtedly had a huge impact because, as the Ofsted report earlier in the year recognised, we were on an upward trajectory, this assault happened, we saw a very significant spike in the number of staff who left us following that incident. Milton Keynes is ferociously difficult in terms of recruitment and we went into a period where we had to concentrate on recruiting to restore staff numbers.**



**As you said quite rightly a short while ago, there is a correlation between high attrition and the impact it has on regime and we felt that. We also had a change of director because the previous director left us at very short notice of her own volition and so we had to also change the local management. So it was a challenging year and I'd be the first to recognise and accept that.**

**I'm also confident that we will see on the next inspection --**

Q. Just before we leave this one, please, if I may --

**A. Okay.**

Q. -- I think the panel will be interested to see the overall approach to safety, please, at INQ001789 internal page 7. This is a report from a visit from June of last year. The safety of young people was found to be inadequate, and I think, in fairness, several themes were pulled out from this, that may or may not relate to what you have been talking about, Mr Petherick. It talked more generally, I think, here about, "The actions governance and oversight of safeguarding arrangements was largely ineffective, which significantly affected the safety of young people".

It said under 2:

"Managers did not adhere to the current safeguarding

policies and procedures."
Under 3:
"Referrals made to the external safeguarding agencies do not show that managers always inform young people about what actions are being taken."
Under 4:
"Child protection records were not always completed to a satisfactory standard."
Various other points, just perhaps to pull out a few over the page, please. At number 8:
"Issues of bullying were not always systematically logged in the way that they should have been."
Over the page, please, at 14 and 15, there were concerns about viewing panels in the bedroom doors and the shower viewing panels and I think a concern that there wasn't sufficient safeguards in place to avoid misuse of that, and still an ongoing lack of CCTV coverage.
So is it fair to say that the inspectors identified a range of safety issues that perhaps go beyond ones which might be explained by turnover or recruitment?
**A. Yes, and issues such as CCTV were in discussion with the Youth Custody Service about the extension of that. Issues such as the shower viewing panels, we have reiterated the instructions, we are looking at the**



**installation of photochromatic viewing panels which would trigger alarms should they be accessed by staff, because it's important in all of these things that we have an approach which is similar to those of an onion in terms of giving assurance and giving governance. Some of those will be technological in type. Some of them will be managerial, staff training and so forth.**
Q. For example, on CCTV, at 15, it said that, despite a concern raised by the previous report, there were still areas where the children did not feel safe because of a lack of CCTV and that funding had been sought but there was no change or plan to improve arrangements. Has that since been changed at Oakhill?
**A. Those discussions are ongoing with the Youth Custody Service in the interim and one of the major areas impacted here are the stairwells and so the instruction to staff, who all wear body-worn videos, is, when they are in stairwells with youngsters and everyone supervising that area, the body-worn video is activated.**
Q. I will take these two further reports relatively briefly if I may. There is one in relation to Parc and one in relation to Brook House. The Parc review, please, report is INQ001798_005. That's December 2017 and the HM Inspector overall concluded in a very positive way -- is this right? -- about the review of Parc?



**A. That's correct.**
Q. Safety had always been a challenge, it said. In the third paragraph, "Recorded violence, although falling, remained too high", but overall the conclusion at the end of that page, "This is a good report. It was encouraging to see many of our previous recommendations attended to which was to the great credit of the director and her staff."
And so, overall, that was a positive report. Is that right?
**A. Yes, it is.**
Q. And finally on the reports, please, although I appreciate you've explained that children are not kept at Brook House, the annual IMB report of Brook House from May of this year, INQ001697_004, please, referred, is this right, to a further Panorama programme, I think broadcast on 4 September 2017. Is that right?
**A. Yes, that is right.**
Q. Which, if we scroll, please, towards the bottom of this page, the last four paragraphs here, this was a different Panorama programme but was, again, a programme which was a described as a watershed moment for Brook House. It showed disturbing scenes of ill-treatment of detainees by some staff. It focused on drug use, violence, the large presence of time-served



foreign national offenders and detainee frustrations with the immigration process. Most centre staff were in total shock. G4S managers moved fast to keep the centre steady, detainees calm and staff encouraged at what was a hugely difficult moment, but it went on to say that the IMB was horrified at the completely unacceptable behaviour of the small group of staff shown in the footage. To be clear, this is a G4S centre; is that right?
**A. It is.**
Q. "We have never witnessed instances of ill-treatment of this kind nor have we had any indications that it might be happening. If we had, we feel confident that we could have taken our concerns immediately to the top management of G4S and the Home Office at the centre. The board has regularly reported on or discussed with management the other issues focused on in the programme. A number of staff have been dismissed and that had led to an impact on morale. G4S has since commenced actions aimed at strengthening its whistleblowing processes and driving cultural change. A recruitment programme looks to increase total staff numbers. There has been investment in redecoration of the centre ..." and so on.
But this reflects, does it not, some pretty serious concerns being raised within the last 12 months?

**A. Yes.**
Q. Is there anything else that you wish to say to the panel about the contents of this report, albeit I appreciate it relates to adult detainees not children?
**A. But some of the issues transcend that, don't they? And it was actually this programme that generated the contact with the Jill Dando Institute, which I've referred to already, and so I think, for me, and in discussions with the IMB at Brook House, they were amazed because they're a constant feature of Brook House in that they have free access to walk around, et cetera, in the same way as I do, and I think it illustrates in every custodial situation worldwide the risk of some staff behaving inappropriately. Interestingly, the -- one of the IMB members at Brook House is a required prison governor of many years experience. In talking to him, he was really surprised because he obviously brings to that role his experience and his ability to talk to staff and detainees and I think it was a reminder to all of us about the inherent risk of a small number of staff behaving inappropriately. Many people will remember the Milgram experiment in the United States back in the '40s, and that is still, worldwide, whether -- whoever provides and manages the custodial establishment, it's actually a risk. It's my job, in my estate, to drive**



**that out and to do my utmost to drive it out.**
**I do that in a number of ways. I can always do more. The important thing, I think, time and time again, is that of the role of leadership, both at the top, at the establishment leadership level and throughout.**
**In my 23 years in the Prison Service, my last five I spent as the area manager for the south-west, responsible for 13 establishments and I know only too well the import of driving the standards, being very open about what is acceptable, what isn't acceptable and absolutely continually giving the leadership and driving the message.**
**Now, at Brook House it still didn't answer all the problems, because there was a small number of staff who acted inappropriately. It's created a lot of questions for us because we talk about consistency of teams in terms of residential units. Somehow I have to get the balance between consistency and sufficient turnover in those teams to stop groups of people, like-minded people positively or negatively coming together. It's a complex situation.**
Q. Thank you. Just a couple more short points, please, if I may, Mr Petherick. For completeness, please, can I adduce your exhibit JP1. It is G4S000005_002. You've



explained to the panel, I think, what the current reporting structure is for the STCs.
**A. Yes.**
Q. If we can just bring up that chart. G4S000005_002, sorry. This is dated June 2018, but is this the current reporting structure in place for the STCs?
**A. Yes, it is.**
Q. How long has that been in place, Mr Petherick?
**A. Slightly different job titles, but overall since May '17 when we brought in a chief operating officer to support me.**
Q. Does this represent a change, then, from the pre-2016 era that we have heard about?
**A. Yes, it does.**
Q. So there is an additional layer of leadership at the chief operating officer level, thank you. You've provided some diversity statistics for the staff, please, G4S000127, internal 26, for both Oakhill for the last -- for this year, 2017 and 2016, the panel can look at those figures. Over the page into 28, please, for Rainsbrook. The panel can look at the breakdown of staff there.
We see figures also for Medway at 29. That's at the leaving time, I think.
**A. Yes.**



Q. We're seeing a broad theme, are we, here, where the majority group among the staff is white British?
**A. That's correct.**
Q. And similarly, at Parc, for the last few years, we see a breakdown there, perhaps unsurprisingly, to include white British, English, Irish and Welsh, but we see the figures there that the panel can look at. Is that right?
**A. Yes.**
Q. Then finally, Mr Petherick, you were asked to review the proposals for reform made by Howe & Co, which I think you have in your bundle. Is there anything you would like to say in response to those proposals?
**A. Sorry, I'm just trying to find the ...**
Q. We can bring it up for you, if you wish, but it should be in your pack of material. It should be at your tab O --
**A. Thank you.**
Q. -- I think.
**A. Yes, got it.**
Q. Thank you. Is there anything in particular you would like to draw to the panel's attention from those proposals?
**A. I think for me, one of the real issues is that I'm very -- I would be very reluctant to move away from**

**primarily a local authority area-based responsibility taking it away into a nationally-led system because, as I said earlier, my experience is very much the important relationships are at the local level.**

Q. Is there anything else about any of the other proposals you would like to offer?

**A. No, I didn't understand 1.6, about, "Chemical restraint techniques on children in custody has ended", because I'm not aware of any such.**

Q. Does that happen in G4S institutions?

**A. Absolutely not.**

Q. I'm grateful. Is there anything else that you would like to draw to the panel's attention?

**A. I think that body-worn cameras should be mandatory and, indeed, are mandatory in G4S establishments dealing with children, because it's been one of the innovations, which actually we started back in 2011, that I think has brought real safeguarding benefits for both children or indeed adults and staff.**

Q. Is there guidance given to staff on when they are to be turned on and turned off?

**A. Yes, and we will take disciplinary action, where necessary, if some -- if the camera should have been activated and wasn't or indeed was activated where it shouldn't have been, and was. So I'm very firm about**



**this because, as I say, we introduced them in a couple of our prison contracts in 2011, against some resistance. I'm nothing but an advocate of it.**

MS HILL: I'm grateful.

Chair, those are all the questions I have for Mr Petherick.

THE CHAIR: Thank you. I think there will be some questions from the panel.

Questions by THE PANEL

THE CHAIR: Could I start by taking you back to Medway, Mr Petherick? You have talked quite a lot about leadership and culture and its importance, and that is indeed significant. The Medway Improvement Board report referred to the fact that G4S was formally Group 4, of course, and was ultimately a security firm and, after the early disorder in Medway was dealt with, that security culture was maintained, and indeed sustained, by internal promotions of some people with the wrong values and approaches. Do you agree with that?

**A. I don't know Medway of the time. I did actually visit there once in those very early days from my role in the Prison Service and I think there is always a risk about only having in situ promotions, wherever, because it can perpetuate cultures. That can be good, obviously; it can be bad.**



**If I go to the wider point, if I may, ma'am, about G4S or Group 4 being a security company, I'm actually very much the MD of a business that cares for individuals. As I say, I worked for 23 years in the public sector before coming into the private sector. I haven't changed my stance from one to the other. My belief structure, my standards, are exactly the same and that's what I see with the overwhelming majority of my colleagues who are like minded and our business is about caring for the individuals.**

**Am I ever challenged by the company about that, because I have seen in earlier transcripts the issue about profit mentioned? I have to say very forcibly and very firmly, I have never been compromised in that way. Indeed, my manager makes it absolutely clear to me that safety and care of the people in our custody is paramount and we will never put that at risk because of the bottom line. I know many observers would say differently. All I can say is from my experience, my perspective, and had there been a risk to that, I wouldn't be working for the company.**

THE CHAIR: I understand your point, but you are here as a corporate witness speaking on behalf of the company and the company's engagement with these issues across the years when you were not involved.



**A. Sure.**

THE CHAIR: So it is important that we understand whether there was that kind of culture being created by the promotion of senior people who carried forward an entirely inappropriate culture to the function of the centre.

**A. Without having personal knowledge, it's difficult to comment and I think I can only comment from the corporate stance of the moment because individuals change and the corporate stance is a very clear one about caring. We aren't just a security company; we operate in a number of fields across the world, so I work within the care and justice field and, actually, both of those words are important to the company as much to me.**

THE CHAIR: Thank you. The next question is about the relationship with the Youth Justice Board and of course its success or organisation now. In particular, relating to Medway, again the Medway Improvement Board have said that the Youth Justice Board could have had more influence on leadership and culture through its contractual arrangements with G4S.

**A. What I'm seeing now, because obviously I'm not sure of the detail of that time, I am seeing a more proactive approach from the YCS. That's been evident over the**

**past 12 months. I'm seeing a more appropriate use of a number of contractual methods. We have good discussions with the Youth Custody Service so I think whatever the state of the relationship was then, we're now seeing a much more proactive and much more assertive, in some ways, culture emerging.**

THE CHAIR: And can you give an illustration of that?

**A. Yes, I mean, post the second Ofsted Oakhill report, obviously we -- we were challenged quite appropriately about some of the elements in that. I think there's got to be a balance in this because it's entirely right that we are challenged about delivery. The risk is if issues become too contractual that will inevitably steer energies and so forth into dealing with the contractual issue, which may be better spent dealing with the actual issue.**

**Now, that's a very fine balance, because we all have responsibilities and accountabilities and so at some stages I would say it's become too contractual. At other stages it could have been more contractual. I think that's perhaps a healthy relationship, but certainly post that time would be one of the examples of how the contractual measures increase.**

THE CHAIR: Has G4S made any form of apology to those who were victims, shall we say, or abused within the regime?



**A. The honest answer is I don't know about the individual cases. What I can say, and I may be criticised for saying this is my approach, but it is and I think it's the company's approach: where we have done something wrong or not done something as we should have done, I personally, and I'm sure the company likewise, has no problem in saying so.**

THE CHAIR: Thank you.

Ms Sharpling.

MS SHARPLING: Thank you, Mr Petherick. Does G4S provide bonuses for its directors on a yearly basis and, if so, on what basis?

**A. Yes, part of our remuneration would be -- over a certain level is a bonus scheme. It depends on a number of factors. I think it's pertinent for me to say that last year I got a zero bonus because what happened at Brook House and Panorama in large parts and I think that's appropriate because it actually shows that it takes into account not only financial measures and financial delivery; other things override that and so it does take into account other factors.**

MS SHARPLING: One of the criticisms in the Medway report was there was a compliance structure in terms of performance and I wondered how the balance was in relation to compliance measures and outcomes for



children and young people in determining that bonus.

**A. There isn't necessarily a direct link. We have to deliver the KPIs otherwise there is a problem but, as I say, using my own example, there is an overarching issue about if we aren't seen to have delivered what we should have done, perhaps one could argue on a moral basis then actually there is a sequence to that and I think that's appropriate.**

MS SHARPLING: Do you accept that if there are higher levels of violence in a closed institution that it could result in less likelihood of a child or young person reporting sexual abuse to a member of staff?

**A. The answer to that is yes. I think for anyone to disclose issues there has to be a sufficient feeling of confidence, of comfort, for want of a better phrase, and so forth and if violence is too high in an establishment of whatever type, the risk is that there isn't that conducive atmosphere that will allow people, trainees, youngsters and indeed staff on occasion to disclose some of the pressures on them and some of the histories they have.**

MS SHARPLING: Thank you. And my last question is if we assume for a moment that transparency is the oxygen of accountability and you are dealing with a closed institution, how can they be made more open to prevent



the sorts of things that we have heard about during the course of today?

**A. Sure. I'm sure you're aware of the advocacy streams and so forth. A lot of this is about us working together with the authority to make sure that we bring in sufficient people. We have the confidence to allow people into our establishments with the necessary permissions from the authority that we welcome and embrace third sector organisations to come and to work with us.**

**Now, there are a number of ways to do that. It's very difficult, I think, to necessarily mandate this, because some of it has to be down to the belief structure, the personality of the person in charge of the establishment primarily, because I can mandate certain things from my ivory tower that actually the people that actually matter are the people on-site and the leadership on-site.**

**So to enable that I have to work very hard to recruit and retain the right people, to give them the necessary freedoms, to define the parameters they're operating in, but to say: this is my belief structure. If you really want to work with me and, for me, you need to buy in to my belief structure, which is one of openness.**

I'm -- one of the things that people can upset me with most swiftly, those people who work with me, is not making sure that they report what they should do and by telling me.

Now, that's my expectation of my managers. That's the one thing they can upset me about very quickly. Equally, I have to make sure that my behaviour actually encourages that and enables that because, you know, when I'm on call for incidents and so forth, I need to make sure that when I get a call I may be challenging, but that I do it in an appropriately supportive way to make sure that people feel they can tell me what's happening without me getting foolish or upset about it because I know in the history of things, and I have had it myself when I've had to tell people that something has happened in my establishment, the reaction from the other person actually will determine some of my behaviours, so there is a whole complex thing of how we reinforce that transparency.

MS SHARPLING: Thank you.

THE CHAIR: Sir Malcolm.

PROFESSOR SIR MALCOLM EVANS: Thank you. First of all, just a point about your whistleblowing policy, which I think builds on your answer to, you know, to the last question. We had this drawn to our attention and



I notice that it defined serious wrongdoing as, and I quote:

"Actions that pose and real and significant threat to the well-being or safety of its employees or others or that may cause serious financial loss."

And then, as it goes over the page, there are a list of illustrative examples and, of course, an appropriate comment about making false allegations.

Do you think this is sufficient to flag the need for whistleblowing in relation to the treatment of detainees?

**A. I think we could spell out more clearly and I'll certainly take that away and follow up with the person responsible for the policy. What I would say is that the secret shopper test I did last on the whistleblowing line was I said I was a member of staff at Oakhill and I was concerned about grooming activities by another member of staff.**

**There was absolutely no issue, no problem about that report being taken seriously and I'm -- I followed it through the stages, to make sure, so that I absolutely take the point about the language.**

PROFESSOR SIR MALCOLM EVANS: Thank you. And just finally, were you or to the best of your knowledge G4S surprised at the revelations in the Panorama programme on Medway?



**A. Oh, absolutely.**

PROFESSOR SIR MALCOLM EVANS: Do you think they should have been surprised if they had had the right systems in place?

**A. Can I -- the pertinent personal knowledge I have is Brook House, and if I can answer that question in response to Brook House --**

PROFESSOR SIR MALCOLM EVANS: Sure.

**A. -- but obviously it follows over. I was appalled by the behaviours that were shown. I knew a couple of the members of staff, not well, but I knew of them because they were long serving members of staff and was really surprised.**

**I walk around Brook House. I hadn't seen that behaviour, but perhaps I wouldn't see that behaviour because people are more astute than that, aren't they, if they want to be negative.**

**The comments from the IMB strengthen my surprise and, as I say, one of the IMB members, ex very senior governor with his experience and he was surprised.**

**I think what it said to me was where there are small pockets of very negative behaviour they will be very well hidden, so the challenge to me and the challenge that I've spoken about with Jill Dando Institute and so forth is what is the learning about how do you expose**



**this, because expose it we are determined to and so forth and we have talked of a number of ways to do that.**

**Some of those are very transactional. So, for example, if we have three or more complaints about a member of staff in a three-month period we will formally sit down and review that with the member of staff. Similarly, if he or she has been involved in three or more issues of physical restraint, we will sit down and we will review that.**

**Sometimes and I'm thinking here about adult prisons primarily, it will be the situation that they're working in, they may be one of the members of staff in a care and separation unit, segregation unit as it would have been known, and we have to understand that but, actually, the important thing is that we are alive to it, we're determined, I give the leadership, I make it very clear that this is not acceptable, never will be and it does come back, as I was saying earlier, into issues such as staff deployment and most of my staff will want to work with people that they know because they will feel more safe, more confident and so forth and I recognise that.**

**On the other hand, you need to have enough turnover to try to prevent any negative groups of staff coming together. That's a challenge not just for me but for**

**every manager of a custodial establishment, be it in this country or be it around the world. That's one of the lessons I have taken.**

PROFESSOR SIR MALCOLM EVANS: Thank you very much.

THE CHAIR: Mr Frank.

MR FRANK: Thank you, I wonder if we could please put up document G4S00005_002 again, please. This, you will recall, was the corporate structure organogram, if we can call it that.

**A. Sure.**

MR FRANK: I wonder if you would help us, particularly in relation to 2016, can you tell us first of all who was the divisional CEO in 2016, up until the time, let's say, at the end of June when you ceased to have overall responsibility, particularly for Medway.

**A. The divisional CEO. There was a slightly different job title but the person is the same, Peter Neden, who is my line manager.**

MR FRANK: Peter?

**A. Neden, N-E-D-E-N.**

MR FRANK: And he's still the same person?

**A. Yes.**

MR FRANK: Who was the managing director of custodial detention services.

**A. Paul Cook.**



MR FRANK: Who was the Chief Operating Officer?

**A. Different title, but it was John Parker.**

MR FRANK: Thank you. Director, must be several of those, no doubt?

**A. For Medway, it was Ben Saunders, who was an interregnum director, who went in after the Medway Panorama programme. Before Ben it was a Ralph Marchant.**

MR FRANK: Thank you. After Ben Saunders was it still him?

**A. No, no, because Medway, Ben was there until 30 June.**

MR FRANK: So co-extensively with you, in fact, in June.

**A. Yes, because I was operating as the MD. Ben was the site --**

**(Overspeaking)**

MR FRANK: I remember, thank you very much. And then the deputy director, head of functions in January of 2016?

**A. I'm sorry, the name's gone.**

MR FRANK: Don't apologise. It might be difficult, but perhaps at some point you could let us know?

**A. Surely.**

MR FRANK: Thank you. And then the managers below that in relation to Medway?

**A. Again, I'd have to come back.**

MR FRANK: I'd be grateful if you would. And then the secure care officers. I don't suppose you would remember those either but if you could let us know I'd



be very grateful.

**A. That would be a whole raft of 70, 80 plus.**

MR FRANK: Certainly, but in any event it will give us an idea of the occupants of those offices during 2016 up until June. That would be very helpful. I hope it's not too onerous to do that.

**A. I'm sure I've got someone who will do it for me.**

MR FRANK: That's very helpful, thank you very much. The next thing I want to ask you is this: in relation to Medway in 2016, first of all, is it right that in the conduct of the management of your contract with the Secretary of State for the Department of Justice there were quarterly reviews in relation to each of the establishments for which you had --

**A. Yes, there should have been.**

MR FRANK: So in 2016, can you remember, were there quarterly reviews in relation to Medway?

**A. I was only involved the one month and that was very much a handover month, so there were meetings. I have to say I don't know.**

MR FRANK: There will be a record somewhere?

**A. There should be.**

MR FRANK: And is it right that at those quarterly meetings all the senior management and the directors would be required to be present?



**A. Generally, it would be the director, potentially deputy director, I would expect in those times John Parker and/or Paul Cook to be present and then representatives from the YCS or the YJB as it was.**

MR FRANK: Thank you. In addition to those who were present, there would also be a what was called an allocated monitor --

**A. Yes.**

MR FRANK: -- from the government department.

**A. Yes.**

MR FRANK: Do you know who that was in 2016?

**A. No, I don't.**

MR FRANK: Could you find out?

**A. Yes, sure.**

MR FRANK: Thank you very much. Can I just ask you in relation to those meetings, they were minuted meetings were they not?

**A. Yes.**

MR FRANK: Are those minutes available?

**A. If we don't have them, because they would have been left at site, the YCS should have them.**

MR FRANK: Thank you, because what we do know is that at those meetings, any complaints, serious injuries or serious incidents, injuries or death would be discussed at those meetings.

**A. Yes.**
MR FRANK: So it would be helpful to look at those to see what was said about the state of Medway in respect of what was drawn to the government's attention.
**A. What I would say is intriguingly, perhaps, we have Oakhill's quarterly meeting tomorrow and I have seen a new package of data coming from the YCS. That really does address that kind of issue.**
MR FRANK: Certainly. And just if I may with this, I think you say -- and I am looking at now at a different document. I am looking at paragraph 43 of your first witness statement. You say:
"Like Oakhill, there may have been CCTV at Medway and Rainsbrook but if so it's unlikely that this has been retained."
Could you help us as to why --
**A. Sure. Generally with any CCTV system there is a 31-day overwrite unless there is a particular incident or a need for a segment to be captured and retained and a lot of this, as I understand it, is to do with capacity of servers, et cetera, but generally I think the industry standard is circa 31 days for overwriting.**
MR FRANK: But when you arrived in June of 2016, there had been incidents in the previous month, previous two months, in fact, where the CCTV might have been



a pertinent piece of evidence, so do you know whether those CCTV recordings were maintained?
**A. I don't, I'm afraid.**
MR FRANK: If they weren't maintained, whose responsibility would it have been to take the decision to destroy them or otherwise get rid of them?
**A. It would have been the -- ultimately the director on-site would.**
MR FRANK: And the director on-site at that time was Rob (sic) Marchant?
**A. No, well --**
MR FRANK: Ben Saunders.
**A. Ben Saunders.**
MR FRANK: Just help us with this: Mr Saunders, where is he now?
**A. He's left the company. I'm not sure where he's working.**
MR FRANK: So far as you know he's alive and well?
**A. Yes.**
MR FRANK: Thank you, that's all I ask. Thank you very much.
THE CHAIR: Thank you. Thank you Mr Petherick.
**A. Thank you.**
THE CHAIR: Thank you very much indeed. We will now take our break and return at 10 past 2.
(1.13 pm)



(The luncheon adjournment)
(2.10 pm)
MS HILL: Thank you, chair. Before the witness is sworn I will just indicate we have further counsel here this afternoon. Scott Matthewson is here representing MTC Novo, he sits in the area near the Metropolitan Police. Thank you.
I'll call, please, Jonathan French.
MR JONATHAN FRENCH (affirmed)
Examination by MS HILL
MS HILL: Thank you very much. Take a seat, Mr French. Chair, I will begin, please, by formally adducing the witness statements from Mr French. The witness statement that has been provided is HMP000416 and I adduce that in full, please, if I may, please, chair.
Mr French, you were governor of Medway -- have been governor of Medway since January 2017. Is that right?
**A. That's correct.**
Q. You have provided some evidence to the panel about the change of management, if I can call it that, from G4S back to the MoJ or HMPPS and you've also given some general evidence about the systems in place for safeguarding and also responded to Mr Wood's report. Is that right?
**A. That's correct.**



Q. Help us then, please, with the background to your arrival at Medway and what you have described as your brief to transform the institution? We have heard a lot about the background to the transfer in 2016, so help us, please, with your role in that transformation process?
**A. So at the time of the transfer and at the time of the Panorama documentary, I'd been governor at YOI Cookham Wood, which is literally next door to Medway and has a similar age group. An interim governor was put in at the point of July 2016 --**
Q. I think just to back up, sorry, just by way of your background, you had been governor at Cookham Wood since 2013. Is that right?
**A. That's correct.**
Q. But you had been working in the Prison Service since 1999?
**A. That's correct.**
Q. In various different roles?
**A. Yes.**
Q. Thank you, carry on.
**A. So in July 2016, an interim governor was appointed and, for personal reasons, that person needed to move on and so I was appointed to take over in January 2017 from Cookham Wood. In terms of the brief, I had a long**

**conversation or meeting with our chief executive officer who was really clear to me that obviously Medway had failed spectacularly and his view was that the STC market wasn't performing sufficiently well and he wanted me to do something different in there. Didn't want to carry on with the same old processes and wanted me to go in there, use my experience of working with this age group in other settings and do something --**

Q. Who were you talking about having these discussions with, just to be clear?

**A. Mr Spurr.**

Q. Mr Spurr. That's S-P-U-R-R, I think, isn't it?

**A. That's correct.**

Q. Yes, carry on.

**A. And yes, to go in there and be innovative and be creative, but create a environment where children can thrive, where children can develop and grow and not be negatively impacted by the custodial setting.**

Q. I think for completeness, please, can we bring up your witness statement HMP000416, internal page 3, please.

You say at paragraph 8 and onwards in your witness statement that you found that the number of children was very low when you arrived at Medway. It had fallen to around six children, I think, at one point, and around 14 when you arrived, but gradually the placements were



reinstated towards the end of 2016. Is that right?

**A. Yes, placements had started to be introduced in 2016, but very low numbers. There was only 14 or so when I got there. I took the view that we needed to test our resilience a bit more, so we increased numbers from -- we sort of doubled our numbers over the next couple of months.**

Q. I think that's because you say in your witness statement that after the Panorama programme in January 2016 the placement of children at Medway had been suspended. So is this right, that children would leave Medway but people would not be coming to replace those children who left?

**A. That's correct, which probably explains the reduction in population that you talked about earlier today, from 55 to sort of 29 at the time of the previous inspection.**

Q. I see. You indicate that staff were still affected by the fallout from the programme and the ongoing police investigation. A number of staff were still suspended, some had chosen to leave. And it was apparent to you that under G4S the turnover of staff had been very high. Is that right?

**A. That's correct.**

Q. Then help us with what you say at paragraph 10 about the culture of the establishment that you identified.



**A. So as I said, I found the culture to be very risk averse, there was a policy of containment. All the children were only really mixed with other children on the residential units. They went to school with the children on the residential units. So you could have a 14-year-old and a 17-year-old child living on the same unit, who went to school together, which seemed very strange, and the overriding, you know, design behind this would seem to be that, actually, if they were able to live together, they were less likely to come into conflict with each other. So children were realistically kept apart from children on other units.**

Q. Your understanding, I think, or your impression, was that this culture had been focused around minimising the risk of children coming into contact with other children in case of possible conflict, but you felt it had an adverse effect overall?

**A. That's right.**

Q. You have given a lot of evidence about the changes that you have made and I will come to that, but perhaps chronologically, before I do that, can I deal with the way in which you've responded to Mr Wood's report, please. We find that at HMP000416, internal page 15 -- sorry, I am trying to take the numbers a bit more slowly this time, but it's the latter part of that statement.



You've dealt there in this part of your statement with Mr Wood's report and you've essentially made the point, I think, in the following page that of the incidents he looked at, the majority occurred before MoJ control was taken of Medway. You say you reviewed the documentation and, subject to certain points of clarification, I think, about exactly what material was available and so on, you broadly would not take issue with his observations as to the adequacy of the response to the alleged incidents. It would seem to me he's quite correct in observing that on the basis of the documentation that has been retained, there is evidence of a lack of support for the children and children who made or were reluctant to make complaints and a culture of acceptance of inappropriate behaviour.

You adopt the written submissions and observations made by the Ministry of Justice. Is that right?

**A. That's correct.**

Q. So as far as that is concerned, that document, I think the broad points that are made about Medway in the MoJ submission document -- I'm not sure we need to bring it up -- are around the points of detail about these particular allegations of grooming in relation to a female member of staff and what happened to her and, secondly, in relation to this group of issues around the

PlayStation and the pornography. Is that right?
**A. Yes.**
Q. Now, help us just, please, a little bit, if you can, with the allegation about the female member of staff who faced a criminal trial. I think the decision not to dismiss her but give her a written warning in March 2017 would have been when you were governor. Is that right?
**A. Yes, that was my decision.**
Q. So perhaps help the chair and panel a little bit with that, would you?
**A. Certainly. So the first time I met this lady was in a gross misconduct hearing shortly after I arrived at Medway. This was some 12 months after the date of when the allegations and indeed the incidents had taken place. Although she vehemently denied any elements of grooming or a relationship having been formed, she had had plenty of time to reflect on her conduct and her behaviour and to me she displayed a good awareness and insight into how her behaviours could have been perceived to be -- to be those grooming behaviours by others. And she accepted that was unacceptable and I also had -- from reading her witness statement to the police at the time of the -- which would have been some 12 months previously at the time that she was arrested, for me I felt that there was a clear lack of**



**understanding about the parameters, the roles and responsibilities of her role as a custody officer at Medway. She described in a statement, on at least three occasions, being a big sister to the children there and that was the expectations of the organisation at that time.**
**So I felt that her situation was a little bit symptomatic of the culture I had inherited. I felt that she had a good insight into how her behaviour could have been perceived by others. Ultimately, it was my decision, it was my risk, and I felt that the risk to the children was manageable and I gave her a second chance. It's as simple as that. She responded well to that and --**
Q. Sorry, just pause there. To be clear, you gave her a final written warning for 24 months?
**A. That's correct, so that is still live.**
Q. Sorry, carry on. You were saying, I think, Mr French, that she's done all right?
**A. She has done very well since then. I haven't had any safeguarding referrals about her, I haven't had any cause for concern about her conduct or discipline since that date.**
Q. Is there anything else that you would wish to add in relation to the group of allegations about the



pornography and the USB stick and the PlayStation, that group of issues, is there anything else you would like to add about that?
**A. The only point I'd just add is the actual act of bringing in the PlayStation was custom and practice at the time, so that wasn't -- that wasn't -- there was nothing deemed to be inappropriate about that at the time. That hadn't been done covertly. Obviously, the act of transferring pornography from a USB stick onto the PlayStation is another matter entirely. That's been the subject of a criminal matter, so that has been fully investigated and is the subject of an ongoing criminal case.**
Q. Is there anything else about the allegations that Mr Wood investigated, or his response to them, that you would like to say? Do you think that covers most of that?
**A. Broadly in line, in agreement with that.**
Q. Turning then to the changes that you had made on taking over from Medway in the middle of 2016. The chair and panel can follow this, perhaps, in your witness statement, beginning at paragraph 12 and thereafter. Please help us with what has been done in relation to staff training.
**A. So we have undergone a kind of whole root and branch,**



**really, prioritised staff training. As I think I mentioned, many staff had indicated to me that other than their initial training under G4S and the mandatory refresher training for restraint, they hadn't had any other training during their whole careers at Medway. And so we found staff -- when we invested in staff and invested in their training, we found a really positive response to that, so we have really prioritised training across a whole range of subjects, obviously safeguarding, child protection and --**
Q. Perhaps pull up paragraph 14 of your witness statement. It's HMP000416, internal page 5, please. I think you set out there, Mr French, the topics that training is being rolled out on: child protection and safeguarding; adolescent development; speech, language and communication needs; and emotional and mental well-being. Is that right?
**A. That's correct.**
Q. Help us with who that's being made available to and on what basis?
**A. So that would now form part of the initial officer training programme that's for the YCS-specific course for new officers. So that would be mandatory training for all new staff before they even go live, but we have identified it as priority training for all of our**

**existing staff who should be transferred across to HMPPS, be they in frontline roles or be they in back-office roles, and we have also opened that training for partner agencies and organisations, so non-directly employed staff as well as my HMPPS staff.**

Q. I think you go on at paragraph 16 of your witness statement to say that separately, perhaps, you've initiated training for staff in awareness around child sexual abuse and I think you're targeting that at the moment on those that have most direct exposure to those issues, case workers and the CuSP officers; is that right?

**A. That's correct.**

Q. Will that, in your anticipation, assist staff in identifying the warning signs in children that they are being abused or also how to deal with children who have historically been abused? Is that your hope from this training?

**A. Hopefully both, yes.**

Q. You, I think, have summarised at 17 that staff had told you that they didn't feel that they were well equipped to deal with the children that they were looking after. Help us a little bit with the Youth Justice foundation degree or perhaps take that topic now. Are there numbers of Medway staff taking that up?



**A. Absolutely, I mean, we're the smallest site within the Youth Custody Service but we have got the most number of staff enrolled on the programme so I think, as of today, we have got about 49 staff enrolled on the programme.**

Q. Out of around 200-and-something nationally, I think, is it, or something like that?

**A. Yes, and it's been a really positive response to that. The next cohort starts in October. We have already got staff lined up for that cohort as well. It's good quality training and, as I said, staff have really bought into the training and the investment in them that we have demonstrated.**

Q. These staff do the studying as well as working at the same time, I think, is that how it works?

**A. That's correct.**

Q. Help us, then, with the roll out of the CuSP officer role to the staff at Medway.

**A. So we rolled out CuSP around about 12 months ago and we just had the one-year anniversary. CuSP is custody support officer and the CuSP itself is a custody support plan, so the idea is that every young person has a custody support plan in place and a key worker assigned to them. There is specific, bespoke psychologically-informed training for that -- for the staff, three-day specific training.**



Q. Just pause there, I think you have said in your witness statement that those staff who are going to perform that role have been given specific training for it?

**A. That's correct.**

Q. I think we heard from Ms Robinson last week that it was around a three-day training programme to perform the CuSP role. Is that what you have offered to the staff at Medway?

**A. Yes, that is correct.**

Q. I'm grateful. Tell us then, please, a little bit about we have seen from the G4S evidence, material about the attrition rate and the turnover rate and so on and you say, I think, that you found it difficult to recruit staff, possibly due to the contents of the Panorama programme. Tell the chair and panel, please, what you have done to try and address that?

**A. So we introduced because -- we recognised this was going to be a problem from before we even started, before we even started at Medway in the July, and we thought this would be a problem, so we had our own bespoke recruitment campaign. We had -- we recruited a firm of recruitment consultants to support us with that process, but our fears were borne out and it was a slow burn, so it took -- you know, for the first six to nine months, we saw very few new staff coming through, but eventually**



**the campaign gathered momentum and we started to see the numbers coming through to the point now that the numbers have come through -- certainly since Christmas, the numbers have come through this year quite quickly to the point that we have now closed the recruitment campaign for officers and we are, if you include those staff who are just going on their training we're fully staffed.**

Q. I see. But is that the first time for some time that there has been a full quota of staff at Medway?

**A. Certainly the first time since HMPPS have been running it.**

Q. I'm grateful. Can you help the chair and panel a little bit about the role of the embedded social workers on-site and what they do?

**A. So there was no embedded social worker on-site when I got there. I'm used to the model of having embedded social workers across YOIs. STCs do not have the same model. I thought this was a gap and I thought it was a safeguarding concern for me that I've worked with them, they provide a valuable safeguarding role in the other establishments that I've worked in. So I approached Medway local authority, I had good connections in there anyway because Cookham Wood is the same local authority and --**

Q. That is -- just to be clear, Cookham Wood we haven't

heard very much about, but that is a YOI?
**A. It's a YOI.**
Q. It's not geographically very far, is it?
**A. It's next door. Medway is built on the grounds of Cookham Wood, actually, but -- so it's literally next door. So, yes, so I got a very warm response from the local authority, very positive and they agreed with -- that they could put a social worker into Medway and so we have had that in place, now, for a number of months. Their role is primarily around assessing children on arrival for signs of trauma, signs of sexual exploitation and working with appropriate authorities around managing that, and also in terms of ensuring that their entitlements as looked-after children are met as well.**
Q. The looked-after children are all of those on remand, is that right?
**A. All of those --**
Q. And some other children, is that correct?
**A. All of those on remand, yes, and those who are convicted who have come out of the care system.**
Q. Does the embedded social worker have any role to play if allegations of sexual abuse are made within the establishment?
**A. We're still developing the role. I've only got one**



**person at this point in time. Actually, I think it's probably fair to say that, you know, if -- when we come to review that position, we probably need greater resources in that level. So if there were allegations, absolutely, yes, but it's still relatively early days.**
Q. But at the moment it looks as if their primary function is to perform or make sure that those children who are deemed looked after get the local authority input that they should be getting, it's the entitlements element and also, as you say, this role of screening all children who come in?
**A. Yes.**
Q. I see. Help us then a little bit more, please, with that issue of the risk assessment that's carried out on arrival.
**A. So children on arrival are subject to a number of risk assessments, risk of vulnerability, risk -- they're assessed around their health needs, they have a comprehensive health assessment, they're assessed around their educational needs and any other risks, as well, so it's a multidisciplinary approach. They have an induction process that goes on for a week, they live on special designated accommodation, a special induction unit for that period of time and they have a full and comprehensive assessment in that time.**



Q. I think you make the point in your witness statement at paragraph 24 that they're offered peer support as part of the induction. The induction also includes signposting for children who are identified as having suffered child sexual abuse or being at risk of it, which ensures that the safer custody team, the healthcare team are notified as appropriate and other appropriate safeguards put in place?
**A. That's correct.**
Q. Does the induction process involve telling children what they should do if they are sexually abused?
**A. There is guidance within the induction material and that includes a conversation with a member of staff and the safeguarding team about what to do if they wish to disclose, yes.**
Q. I see. You deal over several paragraphs in your witness statement, Mr French, with the change to the regime that you have sought to implement. Please just help the panel with the key points of that.
**A. Okay, firstly, around the policy of keeping children apart from each other, I felt that was wrong. I wanted to move to a policy of integration rather than a policy of separation and to teach children that when they come into conflict with each other, they need to learn to resolve that conflict peacefully rather than just avoid**



**that conflict through separation. So there was a real push to promote an integrated centre. We have done that. I really believe that the approach to sanctions and, you know, punishment is ineffective in this setting, so I wanted us to move to a more rewards-based approach based around positive reinforcement and motivating children to behave well rather than punishing them when they behave poorly.**
Q. Just pausing there, I think you made the point in your witness statement that you took the view that the previous regime was overly punitive and was ineffective because it didn't prevent poor behaviour, partly because there didn't seem to be a clear link between the sanction and the poor behaviour, so the child would often be confused and resentful and therefore reinforce their negative behaviour. And I think from your witness statement it looks like it was that cycle of what you describe as resentment and retribution that you were trying to change. Is that fair?
**A. Yes, that is correct.**
Q. You indicate in your witness statement that you visited some specialist schools and children's homes and understood the reward-based approach that they follow. What is the position within Medway now for this sort of issue?

**A. So we have adopted that policy as the foundation of our behaviour management policy along with a number of other policies, and so we have pretty much -- there is still appropriate challenge and there has to be consequences of poor behaviour, but we have moved away from the punishments-/sanctions-based model and we encourage children to behave well and they earn points throughout the day through positive behaviour, positive reinforcement. At the end of the day, if they have earned enough points, that translates into rewards.**

Q. Such as being able to watch TV in their room overnight if they have got enough points to justify that?

**A. That's correct.**

Q. You say that your impression is that children have bought into this policy and it has proven to work effectively?

**A. Yes.**

Q. Can you tell the chair and panel a little bit more then about the youth council that you have set up?

**A. So we were really keen to give children a voice in how their centre is run and have an input into the decision-making processes around that, so we have a youth council, we set up a youth council. It's primarily run by a youth organisation that works within Medway. They meet every week, senior management attends**



**and we consult with them on our new policies and procedures and, you know, we talk to them about how the centre is going and it's really, for them, to give them a voice. They have the opportunity to bring representations from other children to that group, to that forum, and -- so it's about trying to engage young people in the centre. We feel that if young people are engaged in the centre and in the policies, they're more likely to respond well.**

Q. Is the social enterprise initiative related to that, a similar sort of thing? Tell us a little bit about that.

**A. Yes, I mean, it sort of morphed out of just conversations with the youth council about some ideas that they were having about things that we could do and they wanted to be able to invest money back into the centre, so I gave them a budget. When it's gone, it's gone, but they had the opportunity to invest that budget as they saw fit, within reason, and proceeds and profits would get pumped back into facilities for other children at that centre. We thought it developed a really good sense of prosocial responsibility, good acquisition of business skills and innovation skills, et cetera.**

Q. What are they actually doing? Help us understand the scheme.



**A. So, for example, their main scheme, they bought a load of second-hand PlayStations which we were -- very carefully monitored, made sure there was no opportunities for them to have access to the internet, et cetera. But -- I'm not an expert on games consoles, but apparently you can pick up second-hand machines quite cheaply these days and they rent them back out to other children at the centre and they're turning a handsome profit on that particular element, so they're using money from that in order to buy some sports equipment and other bits and pieces. That's an example.**

Q. Two further initiatives I think about the regime. You've initiated a temporary release policy, I think, that gives, is this right, every child more of an opportunity to be available or suitable for temporary release to go to college or work or see a family member or family members or go on a driving test or something like that? There's a greater ability now for children to have temporary release; is that right?

**A. That's correct.**

Q. You have also changed the core day from 14 to 12 hours, which I think is the amount of time children were out of their cells or rooms and you felt it was too long, that by half past 9 they were all often showing signs of being tired, but they were still out of their rooms?



**A. Yes, that's absolutely right. So I felt, walking around the centre at half past 9, it felt quite flat at that time. I felt children were tired and fractious and actually I thought the staff were tired -- not fractious, but certainly tired -- and probably not performing at their best, you know, after a 14-hour shift.**

Q. I think you said that this seemed to result in squabbles at that time of the day. You've implemented a new regime where children go back to their rooms at 7.45 pm, they don't have to go to bed, they can stay in their rooms and so on, but you believe this is a better and calmer way to finish the day and has resulted in a significant reduction in incidents. Is that right?

**A. That's correct.**

Q. Then help us, please, with some of the environmental issues that you have talked about. So body-worn cameras and CCTV.

**A. So one of the recommendations from the Medway Improvement Board was around CCTV in particular. They identified gaps, as I think you've heard from colleagues previously. Gaps, in particular, around stairwells, classrooms and kitchen areas and they identified this as a key safeguarding risk, so we have acknowledged that and we have invested heavily in CCTV.**

**We have put over 70 cameras into the centre, covering all of those areas.**
Q. So just to be clear, I think covering all the classrooms, stairwells and kitchen areas on the residential units. Is that right?
**A. That's correct.**
Q. You indicate that the body-worn cameras that are also now used, they're not compulsory, this is in line with other HMPPS establishments, that staff have generally been positive about them, are encouraged to wear them, and are instructed to activate them whenever there is an incident or they're required to respond to an alarm call?
**A. That's correct.**
Q. If a staff member refused to wear or use their body-worn camera, the manager would be asked to investigate why that was and that they have an additional benefit of having sound as opposed to the CCTV that doesn't. Is that right?
**A. That's correct.**
Q. More generally, you've set out in your exhibit JF2 the investment in the maintenance of the fabric of the institution which I think has overall helped. Is that right?
**A. Absolutely.**



Q. Then tell us, please, about the developments in relation to the use of force and restraint.
**A. Obviously, given what the Panorama documentary uncovered, you know, use of force and governance of use of force was an absolute priority for us and particularly concerns that there hadn't always been transparency around submitting records and documentation so we have really moved to improve our governance around that. The use of body-worn cameras obviously helps with that but we have changed our structures. We have a weekly governance meeting around minimising physical restraint, the local authority designated officer is invited to that meeting, comes to every second meeting, at least and it's a transparent meeting where we can review all uses of force that have taken place from the previous week.**
Q. I think you've indicated that the LADO normally attends those meetings, is that right --
**A. Yes.**
Q. -- to provide an element of independence and transparency?
**A. That's correct.**
Q. Then can we pull up, please, what you have said about safeguarding issues. It's HMP000416 internal page 13, please. So I think you've set out there -- perhaps some



familiar territory for the panel -- a range of ways in which children can report concerns to their CuSP officer, assigned case worker, Barnardos, the Howard League. You've made the point that there is the ability to have a confidential complaint to you as governing governor, there are visits by the HMIP and Ofsted, but you say this at 46, that you eat lunch with the children every day in the centre, so you feel the children have good access to you. The children have phones in their rooms which allow them to call their families and for their families to ring in, and that you have tried to initiate, is this right, the involvement of the Independent Monitoring Board within the STC because that didn't take place previously?
**A. Well, there is no Independent Monitoring Board at the moment and there isn't -- there aren't Independent Monitoring Boards across the STC estate. Again, having worked in YOIs and adult establishments, I have worked closely with Monitoring Boards previously and have found them to be valuable eyes and ears, and this is also for assurance, so I'm currently in conversations with the Chair of the National Independent Monitoring Boards, who happens to be somebody I know, she was due to be the Chief Inspector of Prisons when I was an inspector, so -- and she's very keen that we pursue a pilot at**



**Medway, as I am, of setting up our own Monitoring Board there.**
Q. You describe, finally, at paragraph 48, the quarterly deep dive meetings as well as your monthly safeguarding meetings that are attended by the senior management team and local authority representatives. We take a step back and look at trends and developing issues to do with safeguarding during those meetings. Is that right?
**A. That's correct.**
Q. Just generally, I will come to look at the policies, if I may, just briefly, you've provided us with the Medway child protection policy that's now in place. It's HMP000334_001. That's the December 2017 child protection policy. That I think is agreed at national level, is it, but applied then locally to Medway; is that right?
**A. Yes.**
Q. We can see, I think, in here that this gives guidance on how to respond to allegations of abuse if they're made.
**A. Mm-hmm.**
Q. Does this policy represent an improved version of what was in place before?
**A. Yes, absolutely.**
Q. You have also provided the whistleblowing policy which, again, is December 2017. That's HMP000351_001. Forgive

me I'm not sure you did provide this. I think we perhaps obtained this, but you're familiar with these documents. This is, again, the Medway whistleblowing policy. Is that something that's been expanded or improved from a previous draft, do you know? It's dated December 2017. Has it changed in substance from what was in place before?

**A. Not locally, not since we took over and it's only through -- and it's a reflection of the national policy as well.**

Q. What do you think, then, has been done on your watch, if I can put it that way, to improve the culture of whistleblowing within the institution?

**A. I think it's that we have really pushed the need for transparency in all aspects of what we do. There's been -- you know, staff at Medway are quite clear on what went wrong or, you know, sighted on what happened, what happened before and there's been a real message that it's not just what went wrong before in terms of the actions of small numbers of individuals, but it's actually the fact that those safeguarding mechanisms didn't kick in and that people didn't report what they saw that led to what happened and it led to their professional names being dragged through the mud as much as the people who were carrying out those acts. So**



**a real push around transparency, it's a contractual obligation for staff to do that anyway, but it's also about it's the right thing to do and it's setting the message, setting the tone, and staff having confidence in the systems and processes.**

Q. To what extent is that stressed in the training for new staff?

**A. Absolutely it features as a complete training module within the initial training course.**

Q. Thank you. I'd just like to take you briefly through, if I may, the reports just to pick up the findings of the various inspectorates. I don't need to bring it up but we have already looked at, I think, the incoming situation if you like that you inherited, the June 2016 visit led to a report in August 2016. INQOO1479. We don't need to bring it up. That's the one I think we already looked at which had effectively "inadequate" for effectiveness and safety.

There was then a report based on a visit in March 2017, so just after you took over. INQ001480, please. That was a report published on 13 June and that did still give overall effectiveness as "inadequate" and safety as "inadequate". But I think in the overall narrative at internal page 3 and onwards, it did make the point that there had been some critical actions



taken swiftly while others remained outstanding. It talked about the transformation plans that were in place. I think, in fairness, at 5:

"Inspectors felt that many initiatives soon to be implemented are intended to address key weaknesses."

The panel can see what was said elsewhere in that report, but then, to bring us up to date, you've helpfully provided the report from May of this year based on a visit in March or February and March of this year, and it's INQ001725_001 and you can see, looking in that, that the rank or grade overall has gone up to "requires improvement".

The narrative, if one looks, please, at internal page 3, does say, at the beginning:

"Medway has improved in all areas since the last inspection."

Areas which have the same judgment have nonetheless improved. Various comments made about the initiatives that have been brought in. Perhaps for this panel's purposes, about two-thirds of the way down, "Other safeguarding arrangements" -- sorry, forgive me, the previous paragraph:

"Most safeguarding referrals to external partners are made promptly. A few take too long and lack clarity, which has led to delays in investigating



concerns. Concerns in security reports are not always recognised as safeguarding matters. Child sexual exploitation is not sufficiently well understood, with only a small number having been trained on it. Other safeguarding arrangements have been improved. The value of these plans is better understood by some staff and managers than others. Children are kept safer through the plans that would benefit from being more closely involved in planning and reviewing in line with guidance."

Overall, the panel can see that at internal page 7 the safety score has now gone up to "requires improvement" rather than "inadequate".

Broadly, I think what you say is that this reflects the inquiry -- forgive me, the inspectors acknowledging the work that you're doing but that the work is still ongoing. Is that a fair summary?

**A. Yes, absolutely, I mean, the general thrust that we take from it is that we have made good progress. We have got, you know, affirmation of that from Ofsted and affirmation as to the direction of travel, and we're going in the right direction but there's still a lot to do.**

Q. Is there anything else that you have identified that you consider that Medway can do to improve how it prevents

and responds to child sexual abuse?
**A. I think overall you've heard from colleagues around the strategic priority around reform and I think that is key. The foundation degree is how we have invested in staff. The creation of the specialist youth custody officer is really important. This is specialist work, it needs specialist staff and specialist training and I think the more we can do to invest in the quality and the training in the development of our workforce, the better it will be, just to create an environment where children are safe where they have confidence that their concerns will be taken seriously and trust in the adults that are caring for them to, you know, to create that open environment where disclosure may be possible.**
MS HILL: Thank you, Mr French, those are all my questions, chair?
Questions by THE PANEL
THE CHAIR: Thank you. Mr French, just a point of information noted from the papers that the Medway Local Safeguarding Children's Board had commissioned a serious case review on the abuse at Medway, due to report around summer 2018. Has it reported? I assume not.
**A. It slipped. There are -- I think the latest date for publication is at the end of the year.**
THE CHAIR: At the end of this year?



**A. Yes.**
THE CHAIR: Thank you.
MS HILL: I think we can confirm that, chair. We did check that ourselves today.
THE CHAIR: Thank you. Secondly, your relationship in this role or, indeed, past roles with the Youth Justice Board and its successor organisation, can you describe the nature of that relationship?
**A. With the Youth Justice Board or with the Youth Custody Service? With the Youth Custody Service, it's my own organisation, so I'm line managed directly through the Youth Custody Service. With the Youth Justice Board, that was a commissioner/provider relationship, so I've worked with the Youth Justice Board for a number of years now since 2008 as, you know, in that kind of commissioner/provider relationship.**
THE CHAIR: With the YCF?
**A. So YCS is the arm of my own organisation. It started out life as the Young People's Estate back in June 2014. That was the first time that all the establishments that care for young people came together under one directorate. I think it was from that point onwards that we probably saw some of the investments improving in our estate. We saw some of the policies being developed that we're now seeing come to fruition to**



**a degree, some things we have heard of around CuSP et cetera and other policies and so the youth -- the Young People's Estate is what became the Youth Custody Service.**
THE CHAIR: Yes, and is it a hands-off relationship with them, rather distant, or are they actively involved?
**A. No, no, a very hands-on relationship.**
THE CHAIR: I see.
**A. My line manager visits me regularly at deputy director level. There are other deputy directors within -- there are three deputy directors within Youth Custody Service. They are regular visitors to Medway. The director herself has been to Medway, so I think it's a very hands-on relationship.**
THE CHAIR: Do you have contact with the Ministry of Justice?
**A. Yes.**
THE CHAIR: What's the nature of that?
**A. Less so, I mean, the Ministry of Justice have got the sort of policy responsibility so it would -- my contact is more -- it's more limited often to them wanting to come out to see what life is like, actually, on the frontline, as it were and facilitating that. Probably colleagues within the Youth Custody Service back in headquarters would have more direct, day-to-day contact**



**with colleagues from the MoJ.**
THE CHAIR: Yes, thank you.
Ms Sharpling?
MS SHARPLING: Thank you, Mr French. This is a question I asked the last witness, and I don't want you to think I am singling you out for this question, but it's whether the governors who are employed in the public sector receive an annual bonus and, if so, on what basis is it awarded?
**A. Sadly not.**
MS SHARPLING: Thank you very much.
THE CHAIR: Mr Frank?
MR FRANK: Thank you, just in relation to an answer that you gave concerning the difference between the regime that you have instituted and what you call the previous regime, you started in January 2017?
**A. Yes.**
MR FRANK: G4S were the regime until June 2016, so when you refer to "the previous regime", are you talking about the MMPS between June and December or are you talking about "the previous regime" as the G4S era?
**A. I'm really talking about prior to HMPPS taking over in July 2016 --**
MR FRANK: So that's the G4S period?
**A. Yes.**

MR FRANK: Thank you. Secondly, this: some witnesses have told us that they don't think children can ever be safe in a custodial environment. You have a rating that says "requires improvement". It has been suggested that one test we can apply is, "Would I be happy if my child were to be held in that environment?". With a test result that says "requires improvement", some parents might say, "I wouldn't send my child there for all the money in the world, if it requires improvement. It can't be safe". I wonder if you have a view about whether that's an adequate test, as it were, or would you suggest a different one?

**A. I think there is more to it than just one single test in that sense. Certainly the feedback that we got from Ofsted was very positive and the feedback from them was that we're on the road to being good. For Ofsted, they like to see change embedded and they like to see the changes that you've introduced are sustainable, so although they were very positive about the direction of travel and the -- you know, the changes that we'd introduced, the raft of policies that we'd introduced, the culture that we have introduced, for them it was still -- it was within 12 months of them coming previously, so it's still -- some of those policies were still relatively new, so possibly slightly cautious**



**scores, but certainly the feedback was very, very positive and some of the narrative within the report is positive.**

MR FRANK: Thank you very much.

MS HILL: Thank you very much. Thank you.

Chair, before we move to the next live witness, to complete the Medway evidence, can I just make clear for the chair and panel that, as far as Medway counsel are concerned, Mr Wood confirmed in his report of 13 June -- INQ001255 -- that there was one criticism of Medway Council. That's set out at paragraph 6.1.19. Medway Council has confirmed in correspondence that it has no observations to make in relation to that comment.

I'd like to formally adduce, please, as you've indicated, chair, evidence from the Medway Local Safeguarding Children's Board. There is a witness statement from John Drew at MED000255 in which he confirms that the Medway Local Safeguarding Children's Board had initiated a serious case review. The terms of reference for that are set out at MED000253. There is no report as yet available from that review. As we heard from the last witness, it has slipped beyond the summer of 2018 as was anticipated would be the publication date and, finally, there is an additional document related to this process that I'd formally



adduce, please, MED000256, which is, if I have understood it correctly, the Medway Safeguarding Children Board's individual management review to input into that serious case review. So I think it's a document that amounts to a reflection on its own involvement in these events and perhaps one passage just to draw out at internal page 15 -- we don't need to bring it up. In 2015 to 2016, there were 416 referrals and consultations to the LADO team which included 94 for the STC, which was an increase in referrals attributed to the BBC Panorama programme, but, chair, I will formally adduce, please, that evidence and that completes our evidence on Medway.

So I will move now, please, to call Stuart Jessup to deal with some Rainsbrook issues.

MR STUART JESSUP (sworn)

Examination by MS HILL

MS HILL: Thank you, Mr Jessup, you're the director of Rainsbrook Secure Training Centre; is that right?

**A. That's correct, yes.**

Q. You, I think, were involved in the transition of Rainsbrook, having been director of youth custody from March 2017 on behalf of MTC Novo to the present day. Is that right?

**A. That's correct, yes.**



Q. So rather like the previous witness, you have picked up the institution from G4S and are now still responsible for running it; is that right?

**A. That's correct, yes.**

Q. To try and take your evidence in some chronological order, is this right, that you have explained, please, at internal page 3 of your witness statement MTC000096, your paragraph 21, that you have not been able to respond to the detail of the allegations that Mr Wood had dealt with because Rainsbrook was taken over by MTC shortly after the last of those allegations?

**A. Yes, that is correct.**

Q. Is this right, though, that you have nevertheless in your witness statement tried to respond to some of the themes he identified?

**A. Yes, that is correct.**

Q. Perhaps I could bring that up, please, it's internal page 13, paragraph 80 and onwards. I don't know if it's necessary to go through these points in detail, but broadly what you have done here is gone through those key themes that I think were at the end of Mr Wood's report and you've tried to respond to these themes; is that right?

**A. Yes.**

Q. The panel can perhaps read the remaining pages of your

witness statement, but perhaps just taking these one by one, Mr Jessup, just give us some headlines, would you, on how MTC Novo has sought to address, firstly, the isolation of children within custodial institutions?

**A. So MTC Novo have introduced a number of things to improve the support and to, you know, to remove isolation of young people. So I think one of the main things that we have done is we have revamped the telephony system to ensure that young people can receive calls to their room and make outgoing calls to approved contacts.**

**We have also ensured that all young people are allocated a case worker from the moment they enter custody, but also there's key workers assigned, so there's two key workers assigned to each young person when they're moved across to the living units. The other thing that we have introduced as well is another form of outside contact, which is through the youth portal, which is the use of a tablet. We recognise that the cohort of people that we're working with are used to engaging with technology, so we have introduced the tablets to ensure that young people can make contact with outside on a more regular basis, so --**

Q. It has a secure message system, I think?

**A. Yes. Ultimately, it kind of works like a text message,**



**so you can exchange messages quite quickly. There is a mechanism within that where we can hold the message and then clear it before it goes but most young people are allowed to just simultaneously respond to each other.**

Q. You've talked also about the Barnardo's representatives who visit, the young people can request a Barnardo's visit via their tablet, if they wish. They visit all the young people twice a week. The safeguarding team, you say, has a good relationship with Barnardos and ensures any concerns are shared and children are out of their rooms, I think, between 7.30 in the morning and 9 o'clock at night. Is that right?

**A. That's correct, yes.**

Q. How have you responded to the theme that Mr Wood has elicited of staff perhaps pre-determining or having certain perceptions about the children and that informing how they respond to allegations?

**A. So within my witness statement you will see that we have talked a lot around the Secure Stairs framework. The Secure Stairs framework is a joint initiative with NHS England, YCS and HMPPS, and this effectively is giving operators like myself an opportunity to kind of revisit how we manage young people and the support that's put in for people. It's encouraging --**



Q. Forgive me, I am just going to ask for that to be brought up, because there is quite a bit in your witness statement about this. It's MTC000096_004. This, I think, is a joint initiative between NHS England, the YCS and the HMPPS, and Rainsbrook is an early-implementer site. Is that right?

**A. Yes, that's correct. It's an initiative that will be rolled across the whole of the youth estate, including secure children's homes, STCs and YOIs. For me, it's really given us a different perspective and a different way of looking at how we manage young people. So the key principles to it is --**

Q. Forgive me, perhaps we can go on the next page and try to have the whole page on the screen, please, because you have several elements, I think of the Secure Stairs programme here, the key foundations, and we can scroll in on the top where you break up the "Secure" word into certain elements, or the scheme does?

**A. Yes.**

Q. Then just go down to the next part. The care pathways are then the "Stairs" bit. Is that right?

**A. Yes.**

Q. It will perhaps just help the panel understand what this means in real terms.

**A. So the "Secure" part is the key foundation, so in order**



**to manage young people appropriately whilst in our care we need to make sure that the foundation's right, so that is that the staff group working with young people are sufficiently trained, sufficiently supported, understand young people, understand their history, understand their story and the care pathway is around case formulation and it's around the service that we wrap around the young person -- so understanding trauma, past trauma, understanding all the information that comes before the young person before they come into custody and absolutely utilising the information to develop a care plan that takes into consideration past experiences. So we try to look back to where the root cause of some of the offending behaviour may start and understanding the trauma and how we can actually bring in place a care plan to help the young person understand that and help them to manage that as well.**

**In this, the -- one of the key primary agents of change are our frontline staff, so our frontline staff need to be sufficiently skilled and to have a sufficient understanding of what the young person's history is. So the case formulation, it produces a document for frontline staff to be able to understand the young person's triggers, the different mechanisms to manage young people's behaviour but also different coping**

**mechanisms and I can probably give you an example of one case where we had a young person who was -- had significant trauma and abuse in her past and she was involved in quite a number, quite a significant number of incidents in her time in custody and what we realised through the case formulation was that some of the incidents, it was a reflection of her past and her abuse, so after she'd get restrained, it was the depression cycle and the self-harm that come with it, but what the formulation did was actually challenge the way we actually managed that young person and to the point where we had to encourage and educate staff that, actually, the appropriate response at that point is not to restrain, it's to allow the behaviour just to continue for that period and then intervene.**

**Because of the past abuse that the young person had suffered, it really gives an opportunity then to engage and intervene at the right time to help her understand what had happened previously and give her different coping mechanisms to manage those behaviours.**

**What we saw for this young person upon release was she had been incident free for three to four weeks. She went out at the highest level of level 3 as a rewards and sanctions policy and she's actually gone on to carry on employment into the community, and her**



**local authority, who was very concerned about receiving her back, are quite appreciative of the work that's been done with her.**

Q. I will take this briefly, if I may. I think allied to your Secure Stairs programme, is this right, there is more of a formulation-driven practice that you describe which is -- over the page, please -- a different psychological approach that's perhaps allied with the Secure Stairs framework that looks at trying to identify -- if we see in paragraph 38 -- what are the presenting issues, what are the pre-disposing factors, the precipitating factors, the perpetuating factors and the protective factors for particular children.

The panel can perhaps see, throughout that part of your witness statement, that this has led to increased, I think, psychology provision for children, multidisciplinary meetings on a weekly basis to discuss particular children and their needs. Is that a fair summary?

**A. That's correct, yes.**

Q. Chair, I do have quite a few more questions for this witness and then we do have one more live witness for today. If you wanted to take a mid-afternoon break, now might be an appropriate moment, but I might ask that it's limited to ten minutes, if possible.



Thank you.

So, chair, is it 3.20 pm that we're back?

THE CHAIR: Yes.

MS HILL: Thank you.

(3.11 pm)

(A short break)

(3.20 pm)

MS HILL: Thank you, chair.

Just to continue with your evidence if I may, please, you have provided the panel with a lengthy witness statement. Can I just pull out some of the key topics that you have dealt with, Mr Jessup, in your statement that the panel can perhaps look at. Perhaps we can go briefly through, please, MTC000096_003. You have set out, at the foot of that page and on to the next page, the new management structure that MTC Novo brought in to include a safeguarding team, a head of safeguarding, who manages that team, and a member of the senior management team.

There are, now, differences at the way in which the structure of the management is operated. Is that right?

**A. Yes, that's correct. So since MTC Novo service commencement on 5 May, we have increased our senior management team from what I believe was four to what is now seven. And one of the fundamental changes that we**



**did was we split out safeguarding resettlement. That had been one person before, covering both roles. So we made a stand-alone head of safeguarding who's a qualified social worker and also we created a safeguarding management structure, so in that we have the head of safeguarding. You have a safeguarding social worker, a violence reduction and anti-bullying officer and a SASH coordinator.**

**Also what we did was we pulled MMPR coordinators into that function as well because there are clear lines of responsibility in terms of the management of incidents and the safeguarding issues that can come from that. So we created a stand-alone group, whereas, previously, not much of those roles were part of someone's role previously, so a case worker would have been responsible for violence reduction or anti-bullying. Likewise, the MMPR coordinators, it was part of their existing role as a custody officer or a manager.**

**We have also created an admissions unit, so an early days centre. So this is where all young people, boys, spend their first 48 hours or longer if required, where the staff on that unit, the CCOs, are trained in initial safeguarding and being able to manage that early entry into the centre to settle young people and we also**

**have -- we have a number of young people who act as peer mentors.**

Q. You have made it a requirement that all custody officers wear body-worn cameras, you indicate that staff can face disciplinary action if that does not occur?

**A. Yes, that is correct.**

Q. You have taken certain initiatives, as we can see at 29 and onwards in your statement, around recruitment. You have been looking, I think, not only for enhanced DBS checks but for five years of employment history, personal references and also have been working in partnership with I think it's Amberjack, who are assisting in enabling you to apply a more psychologically-informed approach to help identify resilience within prospective employees. All management staff receive this safer recruitment training. So overall, do you hope that the recruitment processes are now more robust?

**A. Yes, I believe the work that we have undertaken has improved not just our recruitment roles or our retention because we're attracting the right people, we're testing emotional resilience through the assessment of new staff, so I think it's starting to pay dividends now in terms of retention of staff.**

Q. You have set out at paragraph 47 and onwards -- it's



internal page 7 of your witness statement -- the new care management role, I think the case manager, forgive me, who a young person has allocated within 24 hours of arrival. Two of these are qualified social workers and they aim to form a "team around the child" approach. Is that right?

**A. Yes, that's correct. What we inherited from the previous provider was a very fragmented department. What we have done is we have create a care management team which is a multidisciplinary approach which involves resettlement workers, case workers, healthcare education, substance misuse and they're all collocated in order to make decisions quickly, together, in terms of the formulation.**

Q. You indicate that each child has allocated two custodial care officers who undertake the role of key worker, they're required to meet with the child each week?

**A. That's correct, yes.**

Q. That's an initiative that you have brought in. You have also set out, I think, already, at paragraphs 50 and 51 of your witness statement, named healthcare professionals, named engagement and resettlement workers and there is a dedicated resettlement youth mentor who are all hopefully now improving the systems around particular children. Is that right?



**A. That's correct, yes.**

Q. You have set out at 51 and onwards in your witness statement the complaints process and how it operates and I think you have alluded to the fact that the tablets can be used to make confidential complaints and I think you have already talked about the phone lines in place. Is that right?

**A. Yes.**

Q. In terms of staff training, you deal with this at section 57 and onwards of your witness statement. You require all staff now to complete a seven-week training course and to shadow experienced custody officers for two weeks, including completing of the MMPR training. You say the staff is -- forgive me, the training process is strictly monitored. Any staff not deemed to be appropriate or who fail to pass the course will not continue?

**A. Yes. One of the fundamental changes that we have introduced is around our initial training course, so we are, I think, the first centre to -- our initial training course will be accredited, which is aligned to the Youth Justice foundation degree, so it will be accredited to be a youth custody induction award. So this is all staff entering in the centre will be on a career path, so their credits from the initial**



**training course will count towards that qualification.**

Q. I think you -- sorry to cut across you, but you indicate this is a particular qualification tailored to the STC framework but designed to equip CCOs with the skills to work, particularly in STCs, but it is created in partnership with the Unitas Academy, accredited by Skills for Justice and that's for all new members of staff; is that right?

**A. That's right and the psychology team are from the Secure Stairs NHFT -- Northampton Health Trust -- they have had a fundamental input into that training content to ensure that the theme of Secure Stairs is all the way through.**

Q. You have made it clear also in your witness statement that Rainsbrook has 33 officers enrolled on to the Youth Justice foundation degree since October 2017. Is that right?

**A. That's correct, yes.**

Q. In terms of staffing ratios, the minimum is 3:1, I think, as agreed with the MoJ and YCS, but you operate with more staff than that generally in terms of other staff on-site around MPPR and resettlement and things like that?

**A. Yes, the 3:1 is frontline custody officers.**

Q. You've implemented, I think, a process of bi-monthly

supervision -- this is paragraph 65 and onwards in your witness statement. All members of staff now have a bi-monthly supervision session as a minimum, I think, and within the first six months of a CCO's employment they will also have regular clinical supervision by a clinical psychologist. Is that right?

**A. Yes, and that's actually been really beneficial for new staff entering the centre. The feedback to me so far is that it's been a valued asset and it's an opportunity for new staff to actually understand some of the complexities they may have coming into what is a difficult role.**

Q. Just to be clear, the CCO is the custodial care officer?

**A. That's correct, yes.**

Q. You've also mentioned there being more initiative perhaps around objectives and targets in their own personal development reviews and the offer of clinical supervision with a senior psychologist to the case managers. Is that correct?

**A. Yes, that is correct.**

Q. You have set out the process that is to be followed, now, for responding to allegations of abuse which we can perhaps look at in due course in terms of the policy, and you've also explained how the admissions process at paragraph 74 and onwards of your statement now operates,



which I think is where there is reference to the peer mentors that you have already mentioned. Is that correct?

**A. That's correct, yes.**

Q. You have talked about there being a specialist psychology-led harmful sexual behaviour service for those who would benefit from that treatment. Is that right?

**A. Yes, that's led by Northamptonshire Health Foundation Trust. There is two assistant psychologists that lead on that work.**

Q. Finally, a few practical things at paragraph 78 and onwards, the issue that I think Ofsted identified about the shower observation panels and smart hatch systems are being addressed. Is that right?

**A. Yes, we're just waiting for them to be implemented.**

Q. To give children greater privacy?

**A. Yes, it's also auditable, so anybody looking through the viewing panel has to use a fob to clear the glass, which is then registered so we can track who's checking.**

Q. You have made changes, I think, to the night rota and you've also implemented a rewards and sanctions scheme. Is that right?

**A. Yes. The rewards scheme is pretty much as Mr French mentioned. It's focused on positive reinforcement and**



**it's pretty much psychologically informed so instant rewards so we kind of give reward cards throughout the day for behaviours that are good rather than waiting until the end of the day when that behaviour might be lost, which then can be transferred across for rewards every Wednesday.**

Q. I think in terms of the night shift you've made it a requirement that any staff member opening the door of a child's room after 9.30 needs management approval and you rotate the staff so that there is an experienced member of staff on shift at night rather than it being a regular night shift. Is that right?

**A. Yes, that's correct.**

Q. And then the panel can perhaps read this, but what you have tried to do is apply those various initiatives to the themes that Mr Wood identified?

**A. Yes.**

Q. And then for completeness, please -- I will just adduce, we don't need to go to them -- you have provided the safeguarding policy, the security and vetting policy, the well-being of young people policy, the whistleblowing policy, the admissions policy and the body-worn cameras policy that are, respectively, at MTC000093 and 94.

Finally, you have addressed the -- or you have been



asked to look at the August 2017 Ofsted review. Can I pull that up, please, it's INQ001569. And this, I think, is are report based on a visit in June of 2017. Is that right?

**A. Yes, that is correct.**

Q. And although the score of "inadequate" was given to promoting positive behaviour and the effectiveness of leaders and managers, every other element, including the overall effectiveness, was graded as "requires improvement".

**A. Yes, that is correct.**

Q. We already looked, I think, previously at the May 2016 report. That was at INQ001570, which gave a similar grade. It does indicate within this report if we go, please, to internal page 6, that safety also requires improvement.

Can you assist in how you have responded to this report or what your take on it is?

**A. So from the report, I think it was a fair report in terms of where we were in terms of our transformation. We produced a centre Ofsted action plan where senior managers and middle management were allocated responsibility to address recommendations. We have addressed all the recommendations and I think some of the items that we have introduced goes past the**

**recommendations. We are confident that Ofsted will see a complete change when they enter the centre. We're due an inspection at any point, but we feel that we have addressed all the safeguarding concerns.**

Q. And just for completeness, if we pull up, please, internal page 3, there is mention there at the top of internal page 3 under the overall effectiveness heading of the new permanent director recruited three months ago, I think that would be you?

**A. That's me, yes.**

Q. It says:

"Although he is relatively new, it's encouraging that staff at all levels and in all departments at the centre express confidence in his clearly-stated vision for the centre."

And by way of conclusion it says that:

"Although staffing remains challenging for the provider company, gradual progress can be seen in recruitment and retention. Further attention is required to ensure that new staff are sufficiently supported in their roles and to reduce attrition and the steady progress in other areas."

Is that, overall, how you would interpret the report?

**A. Yes, as mentioned previously I think it was a fair**



**you on that, though.**

MR FRANK: All right. I am looking at paragraph 4.1.16 of the policy that you have brought to our attention at page 028 in the relevant document.

**A. If that's in there, that will be the case.**

MR FRANK: Whereas in relation to CCTV footage that's captured that, I think, is kept for a period of six months.

**A. It's 60 days. 60 days normal CCTV coverage. Obviously any incident is kept longer.**

MR FRANK: Right, I am looking at paragraph 9.1.3 of your document:

"Recordings that are required to be kept over a six-month period will be documented in the control room."

**A. I'd have to come back to you on that one, as well.**

MR FRANK: It says:

"All information will be stored for six months or until the system loop requires replacing."

Anyway, it's helpful to know that that is a matter of policy. Thank you very much.

**A. Thank you.**

THE CHAIR: Thank you, Mr Jessup.

MS HILL: Thank you, Mr Jessup.

Chair, just before we leave the Rainsbrook evidence



**report in terms of where we were and I think certainly in terms of the organisation it had faced significant trauma over a considerable number of years and to kind of change that culture and that kind of response to those traumatic issues, I think it was relative to where we were in the long-term transformation project.**

Q. Finally, Mr Jessup, you have been asked to look at the Howe & Co proposals for reform. Is there anything in particular from their proposals that you would like to draw to the panel's attention?

**A. No, I think there's -- I think there is some good recommendations within that. I will probably bring it to the use of chemical restraint techniques that we don't use chemical restraint techniques within the youth estate but, no, I've got no real comment, really.**

MS HILL: Thank you. Chair, those are all my questions.

THE CHAIR: Mr Frank.

Questions by THE PANEL

MR FRANK: Just one question, if I may. In relation to the body-worn camera policy, is it right that the current policy states that any data retrieved from a body-worn camera must be retained for a period of five years in accordance with the Data Protection Act practice?

**A. So for any incident it is kept. In terms of the length of time, I'm unable to answer that. I can come back to**



I will formally adduce, please, evidence from Northamptonshire County Council, the appropriate local authority. I formally adduce, please, a letter from Lesley Hagger, director of Children, Families and Education at Northamptonshire County Council, dated 16 November 2016, NTC000004; a witness statement from Ms Hagger dated 1 May 2018, NTC000026; and an email dated 29 June 2018, NTC000029.

And, chair, we would ask you to read those statements, the second statement in full and the last email in full, because that amounts to the response to Mr Wood's report.

We have flagged on the topics list some general points from the first letter that we would invite you to read.

I will call, please, Mark Johnson.

MR MARK JOHNSON (affirmed)

Examination by MS HILL

MS HILL: Thank you, Mr Johnson. Can you give the court your name, please, and explain the background to the User Voice organisation, just briefly.

**A. So my name's Mark Johnson and I'm the founder and the CEO of an organisation called User Voice. It is unusual in its inception from -- that it's 95 per cent led and delivered by people with lived experience of criminal**

**justice, so that encompasses a range of mental health, prison criminal justice orders, et cetera.**

**We are -- we work in 30 prisons and we work in two-thirds of the probation community around the country now, out of five regional-based offices. We do sort of three things or work in areas of bespoke consultations, so the ones that you see today, we conducted that.**

**We do prison council, which is a democratically elected group of representatives from the prisons that we work in, and we do community council as well, which is a very wide engagement. It consists of sort of like an inverted triangle, you know, wide engagement people self-selecting their own representation, we train them and then they meet with the senior service providers to co-produce solutions, basically, or commission services, so we have just started a -- well, for the last two years, a piece of work with NHS England around offender health and we work in 14 prisons in Kent, Surrey and Sussex around healthcare for prisoners and we have got a system where we procure -- we get service users in any establishment that healthcare is provided with 10 per cent of the procurement school of the healthcare services that get commissioned in that establishment, so it's ... yes.**

Q. Okay, and you have provided a witness statement dated



26 April, I'll formally adduce that, please, chair, it's USV000001_001.

And you were asked some broad questions, Mr Johnson, in preparing your statement around how best children can be protected from sexual abuse in custody. So perhaps deal, first of all, with what you said about I think this theme that the nature of relationships between peers and staff in custody reflects those in the wider community, so please help us, perhaps, with what you see the key themes are in protecting children from sexual abuse.

**A. I mean, the really big issue is about power and the power dynamic in that so in the community obviously adults have power and children and young people don't. In -- if you put that in the secure system that power is amplified and in which case that children, young people, are heavily reliant on the systems and the people that are there to protect them.**

**When they don't, there is a question mark over whether the provision of actually, you know, whistleblowing or being able to discuss openly and supportingly in an environment that accepts the truth and does something about it. I don't know if that answers, but ...**

Q. I think you have made one point in 1.1 of your witness



statement that the very nature of excluding people from normal sexual activity, the volatility and social immaturity of young people in custody are some themes, perhaps, gang issues, peer pressure issues and the threats of actual -- threats or actual violence are also issues, I think, that are you saying these increase the risk of sexual abuse occurring or that these decrease the possibility of a child disclosing abuse or both?

**A. Both. We know historically that the group that ends up locked up or on criminal justice sentencing fall into that category, that they're going to be pre-disposed to all of that that you have just said. We know that.**

**The issue for me and for lots of young people and lots of staff and adults who we work with, which were locked up children would be not that you highlight what the issue is; it's what to do about it if it's happened to you. That's the really big question: how do you live with it?**

Q. And you were asked some questions about the warning signs of children, that they are being abused or at risk of abuse and you talked about this: the institutions fail when they routinely misattribute warning signs as dissidence. Does that mean that institutions perhaps see poor behaviour as poor behaviour alone and not --

**A. I believe in the system there is a skills deficient and**



**I'm not 100 per cent sure on the recommendations, I think they're a bit thin on the ground at the end around the sort of like neuroscience response and stuff of children that have been put through traumatic experiences and stuff, and I think the system that we're sending people into, even the justice system is based on a moral point of children knowing the difference between right and wrong and being locked up on that principle, not the mitigating circumstances or the mental or the neurological side of their reactions to what's happened to them, and that can be misread and it's often misread.**

Q. You say elsewhere in your statement that a child being in custody is a warning sign in itself and you have concerns about whether, if sexual abuse is not responded to properly, then children essentially have reenacted abuse?

**A. Revictimised, yes, absolutely. If you're coming from such a very dysfunctional home, and I'm sure, I don't know, like it's pretty sort of -- wouldn't say common knowledge that the children, most of them, are borne out of a situation where I'd say that the adults need to be locked up as opposed to their children, and they come out of those environments and the thing -- they enter a system which is focused on containment rather than treatment.**

**You've got the people that are involved in secure settings that are -- that monitored predominantly on containment, so on how many people break out or the welfare of them while they're being contained, but once released there is a huge gap in the continuity of any kind of service, which is -- we all know that, as well.**

**So until we get a system that's focused on -- or and the people involved in that system are in the secure estate that are focused on how many people don't come back, rather than how many people break out or what happens to them while they're contained, I think we're going to keep getting the same thing.**

Q. What factors would you identify from your experience are those that discourage disclosure of sexual abuse in custody?

**A. Well, I think the big one is, especially amongst children, is never understanding how I could complain, how I could talk about what's happened to me. There is no provision to do that. Or if it is, lots of the circumstances aren't actually acknowledged so, as I said before, the power dynamic. Sometimes there's not an appetite for any -- for people to disclose at all in certain places.**

Q. I think you have said in your statement that children in the community or in custody might be concerned about the



repercussions of making a complaint or disclosure and some children that you have had contact with have experienced homes, so this is outside custody, in which they were aware of the risk, for example, a disclosure might break up a family?

**A. Absolutely.**

Q. Do you think that risk or that concern about repercussions marries over to custody?

**A. Yes, we have seen it -- you know, sort of time and again you break -- often the system is focused on when it happens is removing the child, for instance, you know, for safeguarding and concentrating on safeguarding. What the system doesn't necessarily look at are the consequences even if that sort of bond or environment is dysfunctional, what the full term consequences are of moving a kid from a family, no matter how broken it is, and that can cause long-term resentments and hatred towards anybody that represents authority and power and that's such a concurrent theme through even older people that have been involved in criminal justice as well.**

Q. I think --

**A. The distrust that comes, as well, with the system. People who are put in positions of sort of psychotherapy, psychological services, et cetera, often they're there to mitigate the risk against the service**



**rather than actually the therapeutic intervention for the individual, especially in a custodial setting, so if I disclose, there's often punitive ramifications of that.**

Q. You have talked about how professionals in your view need to facilitate better education for children about what is sexual abuse. You don't consider that children necessarily understand what is abusive behaviour. Is that fair?

**A. 100 per cent. You know, to know the difference between right and wrong you have to understand that and so often secure estate or young offenders' institute et cetera is the default place that people go to when they -- when they can't cope. So, yes.**

Q. I think you were asked how you consider a child who has disclosed sexual abuse in custody should be responded to, whether or not there are issues with how you understand those responses take place, the support in place for children and so on. What would you like to say about that?

**A. Could you say that again, please, sorry?**

Q. Yes, when a child does disclose abuse what's your view on how those disclosures are responded to?

**A. So, I mean, often there has to be a provision there that's actually sort of for purpose, ie a therapeutic**



**intervention and so often there's not. Sometimes -- and there's all sorts of constraints that exacerbate that, ie the length of time a young person's locked up for, to the sort of skill level of the staff in the environment, to the preparation of relationship with that young person, if we're looking on the outside on an order and you're looking at YOT workers, et cetera, their system is so overloaded that often a young person's view is, like I've had, I don't know, sort of 15 YOT workers over the space of 20 months. I'm not going to disclose to them. Every one I meet wants to know all this in depth knowledge about me, yet I know they're not really interested in me because I have had 15 of them.**

Q. Can I bring up, please, the last part of your statement, USV000001_003 and scroll in on the last two paragraphs, please. I think you said there that in your view there is a widespread skills deficient in supporting people who have been abused. Trauma support should be the first response and you go on to say that institutions in your understanding often have long waiting times for a referral to a professional for up to six months waiting, in some cases, for ineffective short courses of CBT in most cases and you say in the worst case scenario the response to disclosing sexual abuse does little to dispel the shame and does more to reaffirm a person's

victim status. Is that, overall, what you said?
**A. Yes, so we just conducted -- I've actually conducted ten focus groups through the secure system for the NHS recently. The report is going to come out at the end of this month on NPS, novel psychoactive substances in children, and in that sort of group work there and asked the establishment in question, I won't mention it, they said: yes, we have trauma-informed practice here. We offer psychological-based services for children and our practice is trauma-inform, this is the real buzzword, and actually getting into the depth of that of what they offered for a young person is six sessions and that's -- one is it's not enough, it's skimming the surface, it's so dangerous to do that, especially when you're looking at childhood sexual abuse and all of the consequences for that and actually retraumatising the child with having to relive it and then dropping them after six sessions. That's not a service that's anywhere near fit for purpose. I would say that it's downright dangerous to do that.**
**When we -- we need to really delve deeply into sort of the neuroscience behind trauma and the impact that has and I believe that in that, through that door, is the real answer to victim and perpetrator, actually, funnily enough, because there is such compelling**



**evidence to say that actually it's quite similar and that actually the perpetrator is often a victim that's had unaddressed needs that then goes on to become a perpetrator. There is a real link with that and we know this.**
Q. In terms of the future, can I go back, please, to internal page 1 of your statement. You've made two proposals for improvements to the systems. One, the statement of peer-led panels of the sort that you have had success with in adult prisons to give children more of a voice and, second, the introduction of peer counsellors, who have experience of the secure estate as service users, which you believe would offer a better support system. Is that right?
**A. Yes, there is -- for me -- obviously, creating a system which sort of works in the establishments and stuff, there's a really big win on creating what we would call psych education, okay? So poster campaign, literature, videos, whatever, we send the message out there that actually if this stuff has happened to you or what it is and what it isn't, yes, to the wider public and that's -- whether that's children or adults, it's all the same and then the next layer is around where peer support potentially can come in, where trust is gathered because one of the inherent barriers that we have got in**



**this system is distrust, okay?**
**Anybody that represents authority, I will not talk to, because one of the situations I give before where I've been subjected to 60 social workers and I'm over-exaggerating but person after person that's been there by the state, that's for the state not for me, and I'm fatigued and I don't trust anybody that wants to know this information about me within two sessions, right? There is a real issue there.**
**Where peers come in with that is they actually penetrate that barrier, there's no barrier, so one can talk to another without kind of too much fear of reprisal, so you've got psych education, peer support, you've got what you would call, say, group work, yes? And that's like, for me I'd call it education, but I know that that can be misunderstood. We have got this absolute obsession with vocational academic-based education in secure estate and in prison and actually none on basic how I think and feel and exploring that whole thing around navigating thought and feeling, and so I would call that sort of group work. Then you've got the counselling based stuff, so -- and then you've got clinical intervention, ie, you know, clinical psychotherapist, et cetera, of getting involved, so there would be layers to it.**



**The council, for instance, I think what the really big issue there is we have got, as I said, power, so that's the service provision in these establishments. It is pre-set to have an agenda to be successful from the beginning, okay? And these institutions and organisations and businesses have literally pre-set to protect the market interest, so there's a drive, yes, or let me say an agenda or potential agenda to not want to get to the situation where we have got a child, young person, in -- on a platform of autonomy to freely speak, yes, to freely be heard, and I think that's where the councils really slot in there, because it's autonomous and it's also peer-led. It's driven by them. It's not initiated by the service provider. That's really important.**
**What I'm talking about with the council is it needs a little deeper look than just saying: well, we have got a council and we speak to young people. That's not it. It's a look at the power dynamic in there. Is that really the case, is a young person really able to speak, are there provisions for advocacy services in secure estate, do they work? And, for me, the indicator that they work is when you ask the kids: do they work?**
**Now, if you haven't got a provision to ask the kids, you don't know if it works. Let's get that really**

**clear, and that's because it's all adults, again, in powerful positions with an agenda to potentially protect the market interest. What the councils do is provide that provision to listen to the end-user.**

Q. Now, I'd just like to formally adduce, please, the three reports, I think, that you have inputted into over the years, 2011, 2012 and -- well, two reports that you have done jointly with the Office of Children's Commissioner, INQ001129, INQ001607, that deal with young people's views on safeguarding and pulled out some themes around strip searches and so on, that's the 2011 report, and the 2012 report "Why are they going to listen to me?" Was about the complaint system. I think you've perhaps covered the key themes.

**A. Yes.**

Q. I think you're aware of some PPO research in 2015 about the complaints system. That's INQ001560 and so finally just very briefly, is there anything in the Howe & Co reform proposals that you would like to draw to the panel's attention?

**A. Yes, there is a -- I'll probably maybe feed back separately because I'm just seeing these for the first time.**

Q. If you wish to take some time to reflect and put something very short in writing I think the panel would



be grateful.

**A. I will do that. That's what I'll do, yes, definitely.**

Q. Because I know you have been abroad so if you wanted to have some time to look at that, that would be fine.

**A. Yes.**

MS HILL: Thank you, chair, those are my question for Mr Johnson.

THE CHAIR: Thank you very much, Mr Johnson.

**A. Thank you.**

MS HILL: Thank you, if you could look at the list of reforms and provide something in writing, we would be grateful.

Thank you, chair, that concludes the evidence for today.

THE CHAIR: Thank you very much, Ms Hill.

(4.00 pm)

(The hearing adjourned until 10.30 am on Wednesday, 18 July 2018)

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