BROOK HOUSE INQUIRY

First Witness Statement of Nathan Dean Ring

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 15th June 2021.

I, Nathan Dean Ring, of DPA will say as follows:

Introduction

1. My date of birth is DPA

2. I worked at Brook House from June 2009 to September 2017.

3. Prior to this, I was a plasterer and worked in the building trade since I left school in 2016. I have no formal qualifications other than GCSEs.

Evidence

4. I commenced G4S training in July/August 2009 and began working at Brook House in September 2009 as a Detainee Custody Officer ("DCO"). I was ultimately promoted to Detainee Custody Manager ("DCM") after some time spent as a DCO and several application attempts; my employment with G4S was terminated in September 2017.

5. Shortly after the Panorama programme was aired, I received a phone call inviting me to a disciplinary meeting. There was no investigation prior to the meeting, and no opportunity to explain myself. I took my letter of resignation into that meeting because it was clear that the outcome was pre-determined. My resignation was rejected, and I

was dismissed in the meeting on grounds of gross misconduct and bringing the company into disrepute.

6. I returned to construction after leaving G4S, and I am now a self-employed builder working predominantly on listed building restorations.

7. I had always wanted to work in public services, which is what attracted to me to working as a DCM at Brook House. I applied for a prison service job and was awaiting placement, but the role offered to me was too far away from home to practically consider. Through word of mouth, I became aware of openings with G4S at Brook House. I contacted Brook House and was invited to an assessment day.

8. The recruitment process did not prepare me for the role; it consisted of a written and numeracy test, competency-based questions in the interview, and a group exercise. The recruitment process is unrelated to the job itself, and this might be one reason why Brook House had such high staff turnover rates.

9. I am not sure how I would describe the specific culture of Brook House during the relevant period but, staff morale was often low because we were always under resourced and under-staffed; it was a stressful environment.

10. The attitude towards detainees was respectful. If there was something I could do to help detainees, and it was within my means, I would do my best to help them. When I worked as a DCO on the residential wings, I played volleyball with the detainees and tried to build relationships with them. 99% of my interactions with detainees were positive, and the other 1% was trying to deal with issues which arose from the detainees' frustrations at the situation they found themselves in. The simple fact was that there was often only one or at best two employees dealing with up to 140 detainees – if we didn't have a generally good relationship with the detainees then it would have been impossible to maintain any sort of order.

11. My opinion of the management and leadership culture at Brook House was that they were caught between the terms of the Home Office contract and the frustrations of staff. The Home Office contract was, I believe, very prescriptive particularly in terms of how

many hours G4S would be paid for – Staff on the ground however generally felt that Brook House was understaffed. On a good day, we were lucky to have 50 officers in the whole centre. On evenings, you might be lucky to have six DCOs and two DCMs; it left staff on the ground of the centre often feeling vulnerable, overworked and uneasy.

12. As a DCM, I felt caught in the middle of the tension between DCOs and senior management; I was expected to professionally put policies into action but simultaneously, I was also on the ground with the DCOs and understood their concerns.

13. I am not aware of any occasion when anyone raised concerns about the poor treatment of detainees, whether informally or formally as a whistle-blower, and therefore am unaware of what the response of DCMs, DCOs and Senior Managers would have been generally. Nevertheless, if someone had raised a complaint of this nature with me, I would have passed it up to the relevant senior managers and I am confident that they would have dealt with it appropriately.

14. I vaguely remember that in November 2016, HMIP carried out an inspection of Brook House, but I was not shown the recommendations. I have been provided with the action plan by the Inquiry [VERN000116] which I had not seen prior to making this statement.

15. I have been made aware by the inquiry that, as part of the same inspection, HMIP carried out a survey of detained individuals in which 18% said they had experienced victimisation by staff, and 46% had reported it. I never received any complaints relating to this, but because I worked in reception, the complaints I had generally related to missing items or luggage. Generally, if there was an issue with a member of staff, it would be investigated by the designated Safer Community or Race Relations and Diversity Officers.

16. I have been asked to set out my understanding of the role of the following bodies, their involvement at Brook House, and any interaction or communications I had with them:

    a) The Independent Monitoring Board: my understanding is that they would deal with complaints entirely independently. There was a specific complaint form that detainees could complete. A detainee could speak to the IMB if they had an issue

that G4S could not deal with, and if they wanted someone entirely independent. IMB had their own office but would go wherever they wanted in the centre. I don't recall any specific interaction with them.

b) The Gatwick Detainees Welfare Group: my understanding is that they were a local charity who could provide phone cards or clothing to detainees. Detainees could also complete a request form to be visited by this group if they had no family or friends in the area to visit them. I encountered members of this group when they came into Brook House via the visits desk but I don't recall any significant interactions with them.

c) Medical Justice: this body was coordinated via the healthcare team, and they would become involved if the Home Office were trying to deport an individual who claimed they would be tortured.

d) Bail for Immigration Detainees: my understanding was that this body would help individuals applying for bail by putting them in contact with solicitors to obtain legal advice. I do not know anything further about the body other than they were assisting detainees.

e) Any other external organisations: the only other body I remember having regular involvement at Brook House was the police who would take detainees into custody if they had set fire to their room or assaulted an officer.

17. As to the layout of Brook House, it always seemed fairly logical to me and there are no improvements I could think of which might lead to better care for detainees. That said, I have no experience of prisons or detention centres beyond Brook House and Tinsley House; it may be that those with more experience are able to comment more productively.

18. In early 2017, 60 additional beds were introduced at Brook House. Although more detainees were now being housed, the staffing levels remained the same which did nothing to improve either staff or detainee morale. The extra beds were fixed above the existing beds, so it created challenges if staff needed to remove an individual from a

bed on the top level. Concerns were raised about this issue but to my knowledge, no action was taken to resolve it.

19. Turning to E-Wing, it was used for predominantly for removal from association. An detainee would be relocated to the E wing if they had behaved violently, they needed medical observations, they were high risk (coming from prison) or if they were a national security threat. They could also be relocated there for their own safety.

20. What happened whilst a detainee was in the E wing varied depending on the reason why a person was there, and each individual received a bespoke care plan. Freedom was generally more restricted in the E wing as they had to be escorted to other areas of the centre during certain hours of the day. So for example, whereas those on the ordinary residential wings might be able to visit the gym whenever they wanted, those on E-Wing would be escorted there at times when the gym was closed to ordinary detainees (such as meal times).

21. The criteria that needed to be satisfied before someone was moved away from E-Wing lay entirely with the Home Office. If the Home Office said someone had to leave E wing, they did not need to explain the reason to us. If someone was moved for a medical reason and the medics were satisfied that medical danger had passed then the person could return to the residential wings once the Home Office granted permission.

22. Detainees were routinely moved to E-Wing the night before a scheduled repatriation flight; this was so that they were easily located once the time came for them to depart and it also helped to avoid any last-minute protest at their repatriation. If an idetainee was in E wing for a flight and the flight was cancelled, they would be moved out of E wing and back to the residential wings.

23. Someone from the Home Office and a duty director would go down to E-Wing every morning to review the people there and decide on changes to care plans and who might be able to return to the ordinary wings. A person could only be detained on E wing for 24 hours under Rule 40 but the Home Office could extend this period indefinitely. When we moved someone to E-Wing, we had to complete paperwork and provide exact times to the IMB, the Home Office and the duty director.

24. I have been referred to several policies that were in force during the Relevant Period and asked for comment as to whether I was aware of them or not and whether they reflected the reality on the ground at Brook House:

a) Home Office Detention Services Order 12/2012 on Room Sharing Risk Assessment issued September 2016, v2: I do not recall seeing this document, although RSRAs are something that we completed for every individual arriving at Brook House. Individuals arriving from prison would already have an RSRA within their file which could be checked and replicated on our own new RSRA. Individuals who were not arriving from prison did not require an RSRA. Instead, we would check through any documentation that arrived with the person and speak with the individual themselves during the reception process. If any answers to the question were 'yes', then there may have been grounds for the individual to be granted a single room. This would then need to be signed off by the duty manager (usually an Oscar 2, the manager for reception) and be referred to the relevant department concerned.

b) G4S Gatwick IRC's Incentive Scheme Policy (5 August 2014): as the policy states, all individuals arriving at Brook House were placed onto an 'enhanced' level of the scheme, and warnings were often issued to individuals for various reasons. This was as far as it would go, however. Reviews were never carried out if an individual had received multiple warnings. The only difference between the 'enhanced' and 'standard' scheme appears to be the ability to apply for paid work. Any individual could apply for paid work positions, and it was up to the security department and Home Office to decide if and where the individual could work. This incentive scheme involved no real repercussions for unacceptable behaviour. As per the policy, detainees were given a copy of the information and house rules booklet in their own language. If this was not available, then we would use Language Link to facilitate a translated interview to explain the policy.

c) G4S Detainee Reception and Departures Policy (4 May 2016): I was familiar with this policy as it related directly to my role working on the reception. This policy

was fully implemented and followed during my time as DCO and DCM whilst working in detainee reception.

d) G4S Gatwick IRC's General Security Risks Policy: this document outlines very briefly some of the security measures, most of which are covered during the ITC. This would also include the ways in which to report and deal with potential security issues through a security information report (SIR). These were sent directly to the security department to be analysed, logged, and dealt with accordingly. All equipment such as kitchen utensils used by detainees working in the wing would be etched and logged after every service and then daily by a DCM.

e) Assessment Care in Detention and Teamwork: I was very familiar with this policy because I carried out ACDT reviews on a daily basis to ensure the welfare of detainees. This is a document to monitor and support any individual that may be at risk of self-harm. I was introduced to this document during the ITC by a member of the Safer Community Team, and again in the annual DCO refresher training. The documents are case managed by the DCMs and reviews should be conducted in a multi-agency fashion where applicable. These documents were checked and audited regularly by the Safer Community Team. An ACDT could be opened by anyone who had a concern about an individual. There were specific timescales; within an hour, we had to do an initial health plan. We then had 24 hours to review the ACDT with the detainee and someone from healthcare to set out a care plan.

f) Supported Living Plan: I do not recall ever seeing this document. An SLP was a document used to support vulnerable individuals and would work similarly to an ACDT but was more of an abbreviated process. The document was used to aid and support individuals with disabilities or with serious medical issues etc. This document was reviewed daily by the manager running the unit on which the individual was residing, and a care plan would be implemented to support the individual and set levels of observations if required. I was only involved in opening an SLP a handful of times during the reception process. From what I recall, this document served its purpose very well by providing extra support where needed.

g) Minimising and Managing Physical Restraint: I have never seen this document before and assume that it would only be issued to C&R instructors.

h) Violence Reduction Strategy: I do not recall seeing this document before. Aside from receiving IPS (interpersonal skills) training during my ITC, I never received training on violence reduction. However, the contents appear fairly accurate, and were mostly implemented. The anti-bullying strategy was also implemented by the Safer Community Team and involved logging individuals who had claimed to be involved in bullying or who had been bullied. The policy states that managers are trained in risk management and problem solving. As I explain further in my statement, there was no specific training for being a manager.

i) Removal from association (rule 40) care and separation unit policy (22 August 2016): this document details all standards and procedures for individuals located in the care and separation unit, also known as E wing, and previously known as removal from association (RFA) and temporary confinement (TC). To the best of my knowledge, these procedures were always implemented.

j) Age Dispute Policy (reviewed 13 April 2016): I was aware of this policy which was implemented and followed. 9 out of 10 times, the Home Office would be able to confirm the individuals age as they had already been assessed. If this was not the case, a multi-agency risk assessment involving the Home Office, healthcare, DCMs, and senior management team would be completed whilst waiting for an age assessment to be carried out. This could involve moving the individual to E-wing, changing their regime and/or placing them onto an SLP (supported living plan) to monitor them.

k) Detention Services Order 03/2015 handling of complaints (Feb 2017 vs): I do not recall ever seeing this document, but I did deal with complaints, and I discuss the complaints handling procedure in more detail further in my statement.

l) Home Office Detention Services Order on Management of Adults at risk (Feb 17): I do not recall seeing this document before. The policy appears to outline general day to day duties within the centre and when and how to report details of individuals

that may be at risk. Details could be flagged at the reception process, healthcare screening, induction process or any other time that an individual reports or appears to be at risk to themselves or others. The information could be reported and logged through the ACDT or SLP process and could involve moving the individual to E wing for their own safety. Any changes in circumstances would then be reported to DEPMU and the Home Office via an 'IS91 Part C'.

m) Gatwick IRC's Drug and Alcohol Strategy (2017/18): I have not seen this policy and believe it was implemented after I had been dismissed. There were two medical beds in the E wing that were used to house individuals that arrived at Brook House on methadone programs or were drug and/or alcohol dependent. Those individuals would be assessed regularly by healthcare staff because they were allowed to be moved into the general population.

n) Regimes & activities policy: I do not recall ever seeing this document as I did not work in activities, but it appears to describe all of the activities that are available to individuals at Brook House and Tinsley House. The document also sets out the timetable for activities available to detainees, which appears to be an accurate reflection of what happened on a daily basis. These timetables were also displayed on each wing notice board.

o) Removal from association policy (august 2016): this looks identical to the removal from association policy (CJS000725) referred to above.

p) Detention services order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42): I do not recall seeing this document. It provides guidelines for placing individuals under detention rule 40 or 42. Although this was never part of my day-to-day role, I occasionally became involved in this process and dealt with individuals on E wing. Upon reviewing the policy, it appears to have been implemented and worked well for those who needed it. As stated in the policy, DC rules 40 and 42 were used for the minimum time possible and not as a punishment. Ass this process, along with the reward scheme provided no punishment for refractory behaviour, there was little incentive for individuals to comply.

q) Home Office Detention Services Order on care and management of detainees refusing Food & Fluid: I was aware of this process which was implemented and followed. If an individual missed either lunch or dinner in a 24-hour period, an ACDT would be opened. However, it was often the case that individuals would buy and eat their own food from the shop located on the first floor rather than eating a meal provided to them, due to personal preference. These individuals would continue to be monitored through the ACDT food and fluid refusal process as they were not taking the food provided by the centre but had in fact eaten a shop bought meal.

25. Policies and procedures were never drummed into staff. Notices were placed into ring binders in the staff room, but it was up to staff whether they read them. I used to go through a lot of the policies, but mainly the ones that related to my role. In my opinion, very few staff went through the policies, but they would know what needed to be done just from learning on the job. Everyone was aware of the key points they needed to take from a policy without going directly to that policy. The policies were not that visable because they were just placed in a folder and there was no notification when a policy had been updated. When I was promoted to a DCM, there was no extra training aside from a couple of hours going through the ACDT process as I was now a case manager. Aside from this, there was no additional training and you just learned on the job. I did not have any DCM specific refresher courses.

26. The general training that DCO recruits undertake is an 8-week initial training course. I attended this course in July/August 2009 before I began working at Brook House. The course consisted of 6 weeks classroom-based training, a week of control training and a week of first aid training. During the 6-week period, there was a week of shadowing staff in various areas of the centre. I learned more during that one week of shadowing than I did during the whole 8-week training period. I have been provided with an 8-week schedule for a DCO initial training course by the inquiry (CJS006085); however, my ITC never involved a second week of shadowing.

27. There was no specific training for the role of DCM as opposed to DCO. I believe that more time shadowing staff would have better prepared me for both the role of DCO and then later, of DCM.

28. I was promoted to DCM after around three years of working at Brook House. I had previously applied (unsuccessfully) for the role of DCM several times and the questions were the same each time. I am not sure why I was unsuccessful on the previous occasions but I'm sure that going through an identical process in each recruitment drive helped me ultimately.

29. Reflecting on my time as a DCM, I consider that training on Removal from Association (Rule 40) was necessary to fulfil the role of DCM, because there was specific paperwork that had to be completed and various people to notify. There was no training on this, and I learned on the job.

30. DCOs had a refresher course every year which was a day long and would run (inter-alia) through the process of opening an ACDT. We also had refresher C&R training annually and first aid refresher training every two to three years.

31. I don't recall any specific or additional training for staff who were also activities officers.

32. I did not receive any DCM specific refresher courses.

33. I attended personal protection training when I joined G4S in July/August 2009 and then annually in May/June. My observation on the delivery of the personal protection training is that it was very limited as it was only for one day as part of the wider C&R training.

34. C&R training was delivered when I first joined G4S and then annually. Whilst the quality of the training was useful, I preferred on the job training. C&R is perhaps the most daunting aspect of the job so more time shadowing staff doing a C&R would have been better at preparing us for the job.

35. I have been provided with a job description for the role of DCM by the inquiry (CJS004296). This gives a very brief description of a small number of day-to-day tasks that a DCM is required to undertake. Other duties and responsibilities included completing employee development reviews and audits for different areas for the centre, dealing with paperwork for detainee releases, ACDT reviews, monitoring the reception and release processes, dealing with complaints and monitoring visits.

36. As I have said previously, I always tried to engage with detainees in a respectful and friendly way, where there was a language barrier I used a combination of techniques. Language Line was easy to access and was used often for ACDT reviews; you would call and ask for an interpreter to facilitate a three-way conversation on speaker. I also asked other members of staff and detainees who spoke different languages to assist in translating to overcome language barriers in day to day exchanges.

37. I was not aware of any racist attitudes or behaviour amongst staff; it was not something that would ever have been tolerated; I know that an example features on the Panorama documentary and I was shocked by it, I never saw or heard anything like this.

38. Equally, I was not aware of any homophobic and/or misogynistic behaviour amongst staff during the relevant period. Staff were from a variety of backgrounds both in terms of ethnicity and sexual orientation so racism, homophobia and other prejudices simply had no place. If any complaint of this nature was reported, I am confident that it would have been dealt with immediately and appropriately.

39. I was aware of one member of staff bringing cannabis into Brook House for his own personal use. He was walked off the premises by police who would often arrive unexpectedly to carry out random spot checks for drugs. He never came back, and I am unaware of any other employees bringing drugs into Brook House for personal use. Other than this, Owen Syed was friendly with detainees and gave cigars to them one New Year's Eve but this is more an example of the reality of our relationships with the detainees – they were overwhelmingly respectful and friendly.

40. I never experienced bullying by any other staff at Brook House and never had to deal with staff complaints regarding bullying. If there were complaints of this nature, they would have gone to senior management or the diversity officer, which did not happen as far as I am aware.

41. I did not have a working relationship with any external Home Office staff. My working relationship with the internal Home Office staff was friendly. They would be in the morning meetings where all the DCMs and senior management would go through a handover. If I was doing an ACDT review, I would also speak to Home Office staff beforehand. For example, if an individual was thinking of harming themselves, or if they had a flight the next day and I would be thinking of increasing their observations, I would run this by the Home Office first. Another area they would become involved in was an detainee was subject to a Detention Rule 40 as the Home Office managed the time limits. As I previously mentioned, a person could not be detained for more than 24 hours in E-Wing unless the Home Office extended this period.

42. Another area the Home Office became involved in was if an individual was coming through reception who was high risk, I would speak to them to check they were aware that the person was coming in. If someone was vulnerable or at risk of harming themselves, I would speak with the Home Office about their case to make sure that there was nothing about to happen (such as a repatriation) which might provoke them; if there was then I would up the number of observations I would carry out.

43. When it came to balancing immigration removal procedures with individual welfare, I do not think the Home Office were overly concerned with individuals who claimed that their mental or physical safety was at risk if they were deported.

44. My relationship with senior managers at Brook House was generally positive. They were approachable and I could speak with them as and when needed as they were in an open plan office on the top floor. There were obviously frustrations which were shared by many of the staff but I also had an appreciation that there was little that the senior managers could do about those frustrations.

45. My experience of being managed at Brook House was limited to my EDRs; I remember one taking eight hours over the course of two days. My working relationship with my direct manager changed over time. Towards the end of 2017, my manager was Chris Milliken who was the previous Director's son. He came in as a DCM and quickly climbed the ladder. I had the impression that he only got the job because of his dad, but the relationship was professional and ultimately, I thought he did a good job.

46. My opinion on the quality of the leadership at Brook House is that, whilst the door was always open, their ability to improve situations was restricted because they were bound by the Home Office contract.

47. I did not manage DCOs during my time at Brook House because I only line managed ACOs, who I monitored through the EDR process. The ACOs had a probation period of 6 months and then an annual EDR. The ACO training course is (I think) around half the length of the DCO training course which is 6 weeks. The DCO training course is completely different, so I do not know what training the ACOs would have completed. During the EDR, I would identify any specific areas of training required and recommend this on the form.

48. I had a positive relationship with the other DCMs. They were all reliable and competent in their roles.

49. The role of DCMs at management committee system meetings was to provide a handover of what happened the previous day and set out a plan for the following day. In attendance at the morning meetings was the healthcare manager, the Home Office manager, and the DCM on duty for the day. The Home Office would also highlight any high-risk individuals on their list of detainees arriving at Brook House. The meetings were effective for the day to day running of the centre.

50. I had daily contact with healthcare staff whilst carrying out ACDT reviews. Whilst healthcare could not divulge too much information on individuals due to confidentiality, they were helpful during ACDTs with regard to a detainee's ongoing medical needs.

51. Healthcare staff were also present during a C&R and could raise concerns about an individual's welfare before, during or after the C&R in the debrief. If an individual had any cuts or bruises, these would be noted, and healthcare would carry out an assessment. Similarly, if healthcare considered that a C&R had to be terminated due to an individual's wellbeing, then it would be stopped. The attitude of healthcare towards detainees was positive, respectful and caring as you would expect between any medical professional and their patient.

52. My involvement in disciplinary investigations was limited to investigating absences when a member of staff had been absent on 3 occasions in a 6-month period. My only other involvement in a disciplinary meeting was when I was absent for a month in 2015 due to a **Sensitive/Irrelevant** and then in September 2017 when I was dismissed.

53. I was never involved in any grievance investigations as this was dealt with by senior staff.

54. The Home Office contract required G4S to provide 668 hours of DCO time per day and required at least two DCOs on duty in each residential wing throughout the day. I consider that staffing levels at DCO level were inadequate to enable staff to perform the functions of their role. We would have needed at least four DCOs for staff to perform their role effectively. I explained earlier in my statement that it was often a case that a DCO would be left on their own manging a wing. When I first started working at Brook House, I was the only DCO working a night shift on the C and D wings, whilst also carrying out ACDT observations.

55. I had previously raised concerns regarding inadequate staffing levels with Nathan Ward when I worked at Tinsley House. The response was words to the effect of "you have managed until now, so carry on". After I was told this, I did not raise staffing levels again at Tinsley or Brook House. I am not aware of other staff raising concerns over staffing levels.

56. I did not have any input in the September 2017 review of staff arrangements. I have been provided with document CJS000736 by the inquiry which outlines a 3-month

action plan. I have never seen this document as it was only produced two days prior to my dismissal.

57. In my opinion, the staff shortages did not have so much of an impact on the care and treatment of individuals as it did on staff morale.

58. I do not consider the healthcare team were short staffed because they could call in agency staff if required. Individuals were able to access healthcare to ensure their medical and welfare needs were met. There was an open clinic for individuals to see a nurse, and if there was an emergency, a medic would arrive promptly.

59. I was involved in only a couple of recruitment days at Brook House. The process was the same as I described in my own recruitment process; I was involved in assessment days consisting of a written test, competency questions and then a group exercise which we assessed at the end.

60. Brook House was able to recruit staff easily and we received more applications than there were positions. The starting salary was around £25,000 which was attractive for a younger candidate who was applying for a role in activities as they thought the role would be easy. However, there was a high turnover of staff because a lot of the candidates were inexperienced. Some candidates never came back following the training course or decided that after a month of working in the role that it was not what they expected. It was the residential side which suffered the most with retaining staff.

61. Brook House received some applicants from Gatwick Airport because G4S had a contract at Gatwick Airport for guarding the planes. G4S lost that contract, and they relocated staff to Brook House. I was involved in assessment days for some of these candidates and there was a consensus that some of them were unsuitable. Despite this, I saw the same candidates on the ITC (initial training course) a few weeks later; G4S had to place them somewhere.

62. If the recruitment process was explicit about the role and there was more shadowing in the early stages, I think that this would improve retention rates.

63. The introduction of a new contract in 2017 simply resulted in a new shift pattern which I do not believe made any impact on the retention of staff.

64. I had a professional relationship with the staff from Tinsley House when they were working at Brook House. The staff from Tinsley House received the same ITC as other staff at Brook house.

65. I worked on the reception as a DCO and the process by which individuals arrived could be very time consuming. There was a processing desk and two waiting rooms. Detainees would arrive in coaches, have their paperwork checked, be searched by staff, and asked to wait in a waiting room while their property was searched by officers (in front of them) before waiting in the second waiting room to be assessed by the healthcare team. There was a kitchen for staff to prepare meals for new arrivals and, if it was particularly busy, I would take food to the people waiting on the coaches. The length of time it took for people to be processed varied depending on how many individuals were arriving at any one time. Typically, it could take 30 minutes to process a person. If there were two coaches of people arriving for a flight, then it could take all day to process everyone because only six people were allowed in a waiting room at a time. I would take food and drink to anyone who requested it at any point, even if they had not yet come through reception.

66. The time it took to get individuals through reception was a process which we were constantly trying to improve.

67. I have been provided with a copy of the induction policy by the inquiry (CJS006042). This policy was mostly followed when it was introduced. Individuals would go to the B wing (induction wing) for their first 24 hours and were only supposed to be relocated into the general population after their induction paperwork had been completed. However, due to some of the induction paperwork occasionally taking longer than 24 hours to complete (e.g., if religious affairs or activities did not attend to the wing daily to see new arrivals) this sometimes resulted in individuals being on B wing for extended periods. Because the B wing was a smaller unit than others, it filled up quickly and it was generally required for new arrivals to be housed immediately into the general population wings.

68. Lack of activities was never a concern raised by staff or detainees insofar as I remember, and I do not think there was necessarily a need for more activities to be provided – a lot of facilities and activities were being provided.

69. I was not involved in the immigration Rule 35 process as a DCM and am unable to comment on how easy it was for individuals to be seen under the Rule 35 process or how swift it was. As far as I am aware, it was the healthcare team who were involved in this process.

70. During my time as DCM, I only led two or three C&Rs. A DCM or an Oscar 1 would generally be leading a C&R and I was generally an Oscar 2. As an Oscar 2, I would be filming any planned C&Rs. During my last 6 months, I do not remember being involved in any C&R. I do not recall having any concerns about C&R incidents in which I was not involved but which I became aware of through my role as a DCM; planned C&Rs were generally routine.

71. To the best of my knowledge, C&R techniques were not used excessively or as a mechanism to control behaviour. Aside from the planned events, I can only count a tiny number of times where an unplanned C&R took place during my employment at Brook House – certainly less than 10. During my initial training course, I was told that our voice was our best weapon, and we were taught to reason with detainees. This was a successful strategy which is why C&R was used so infrequently; it was also an essential technique given that you would often find yourself alone with over 100 detainees.

72. I received no training in relation to individual welfare, specifically in relation to the mental health of individuals. There was a resident mental health nurse present who I would report any concerns about an individual's mental health to during an ACDT review.

73. I would manage the mental health and wellbeing of individual in general via the ACDT process and I could facilitate meetings with the resident mental health nurse. There were some mental health issues which we might not have been aware of (e.g., if an individual had anxiety, they could speak with nurse directly who would refer them onto

the resident mental health nurse). It was only more severe cases, like self-harm, that would be notified to us which would trigger the ACDT process.

74. Drug use by individuals was an issue at Brook House which staff were constantly trying to combat. Spice was a particular problem because its components can be altered so it is no longer detected. It could enter Brook House in oil form; a painting which looked like a child's painting had been dipped in oil which could be torn off and smoked had come in via visits and was non-detectable. Drugs were also being concealed inside of tennis balls which would be hit over the fence into the courtyard, so we had to then check the courtyards on a morning.

75. In the Panorama programme, one of the nurses makes a comment that visitors would bring items in with drugs concealed inside and pass them on. I never witnessed this myself. All post would be x-rayed, and parcels would be opened by the security team. If individuals were caught with drugs, the police would be notified.

76. I feature in the Panorama programme when an individual has taken spice. This was the fourth time I had called for a medical response for this individual, and on each previous occasion I had spent time with him talking about the effect the drug was having and why it wasn't a good idea; I thought I had gotten through to him and then I saw that he had again, overdosed. It was the disappointment of the situation that led to me making a stupid comment.

77. I was not aware of any drug rehabilitation centre at Brook House or associated with it.

78. Chaplaincy never raised any concerns about welfare with me personally; however, if they did have a concern about an individual, they could open an ACDT.

79. If an individual had self-harmed, this would trigger the ACDT process which was an effective process because it set up a care plan for that individual. For example, if an individual's flight had failed, they would be provided with details of a Solicitor who could assist them. The care plan would be reviewed with other agencies, and the individual would be observed frequently.

80. If an individual had refused food provided by the centre within a 24-hour period, an ACDT would be opened. The only meal which was not monitored by Brook House was breakfast. Often, individuals preferred to buy their own food from the shop as they disliked the food at the centre. However, because they had not taken a meal from the kitchen, they would be marked down as refusing food. If staff then saw that the individual had eaten, the ACDT could be closed but the pattern would reoccur daily so often, the ACDT would be left open.

81. The Panorama programme shows Callum Tulley reporting to me that an individual had refused food. This individual had been in Brook House for a few days, and I had been doing all I could to help him. The detainee refused to eat food provided by the centre canteen but was purchasing from the shop. I was aware that he had plenty of food in his room from the shop and had seen him eating his own meals; I knew that there was no welfare issue. This was frankly, a 'piece for camera' by Callum and if he had genuine concerns, he ought to have opened an ACDT; he did not do so.

82. I worked on reception when TSFNOs (time served foreign national offenders) arrived. They would come through reception and be treated in the same way as any other newly arrived detainee.

83. For detainees who arrived from prison and who had not completed their sentences (i.e. were being released early) they would be placed on E-Wing pending deportation. If their flight was cancelled, they would be returned to prison; they would not be released into the general Brook House population or otherwise kept on E-Wing.

84. My experience of caring for TSFNO individuals was that, if they had completed their sentence, they would be treated as any other ordinary detainee at Brook House.

85. The co-habitation of TSFNO individuals and other detainees did not create difficulties in my opinion. We would try and pair individuals up in a room as appropriately as we could based on their background. However, ultimately, if the centre was too busy, detainees would be put wherever there were beds available.

86. I do not recall witnessing any verbal or physical abuse of detainees whilst working at Brook House by staff.

87. The complaints process for individuals or others making a complaint relating to mistreatment was to complete a complaint form and place it in a padlock secured complaints box; these boxes were located on the walls of each of the wings. I sometimes helped individuals fill out their forms, which would go into the secure Home Office box and would be sent to the Home Office. The Home Office would then liaise with the complaints and audits teams. Occasionally, I might have been issued a complaint to review, but this usually related to missing property. I would check the CCTV and send my investigation report to the complaints team who liaised with the Home Office.

88. Any complaints about staff would be made to the safer community team.

89. I was involved in an internal investigation conducted by G4S on one occasion. I had a telephone interview, but I cannot remember what was specifically discussed. I cannot remember what the issue was now but I was involved as a witness rather than as a party to the investigation.

90. I do not think the complaints processes could be improved as to the best of my knowledge, it was entirely independent of the G4S staff.

91. There was one complaints procedure for all matters. If there was a complaint regarding healthcare, I would have thought that this would be referred to a healthcare manager, so I did not have any involvement.

92. Callum Tulley worked in activities, so I did not work with him directly. I would spend my lunch in the gym, and he often did too, so this is where I knew him from mainly.

93. I appear in the Panorama five times. The timings of the footage where I appear are as follows: 15:30- 16.49, 14:40 – 41:02, 41:21 – 41:30, 47:26 – 47:42, and 48:04 – 48:07.

94. I cannot comment on the impact the Panorama which aired on 4 September 2017 had on staff morale as I had already been dismissed by that point.

95. The Panorama affected me personally; my wife and I received a lot of abuse. I do not seek to condone or excuse the comments I am shown to make but as I have set out previously, there were, in each instance, reasons why I made them. The combination of the stress of Brook House and the unending cycle of repeat problems (such as drug abuse) which I had no power to change, led to frustrations which manifested themselves in the comments I am seen to make. I want to be clear though that I do not recall ever making abusive or anything other than respectful comments towards sober detainees in my conversations and interactions with them. I liked many of the detainees I worked with, I spent time with them, played football with them and encouraged the ACOs and DCOs below me to do likewise.

96. The comments I am seen to make during the documentary were in every case, taken out of context; in the case of the clip where Callum expresses his concerns for the detainee apparently refusing food, this was to my mind, Callum acting unfairly to generate content for the documentary; I believe he knew that the detainee was eating, albeit away from the canteen.

97. During the programme, one individual says that they are under the age of 18. I did not deal with this person, but anybody who claimed to be underage would be referred to the Home Office who would relocate them to the E-Wing for their own safety and arrange an assessment with healthcare. I do not know what that assessment involved. Any individual who was found to be underage was released into social services.

98. Because I was dismissed shortly after it had been aired, I am unable to say whether there were any changes at Brook House following the Panorama programme and whether they were effective in bringing about change.

99. I do not have any suggestions on how Brook House can be improved other than increasing staffing levels and improving the training. Brook House is built to category B prison standards and is essentially a category B prison with a different sign on the door; its layout and infrastructure suit this purpose.

100. I am asked for my recollections about a number of people who worked for G4S during my employment and during the Relevant Period, these are as follows:-

a) Steve Webb: he was originally in another family suite, and I only knew him through training as he was a C&R instructor. He then became a DCM and worked opposite shifts to me, so I never worked directly with him.

b) Chris Donnelly: he was an Oscar 1 and started as a manager before I started. We always worked in pairs on the same shifts, but he was on nights so we would see each other on the handover. I did not know much about him and only saw him a handful of times.

c) Kalvin Sanders: I only saw him a handful of times as he was not there for very long. He was on residential which was not my area, so I never worked with him directly.

d) Derek Murphy: he was a residential DCO in the E wing. I knew him fairly well because I had to do ACDT reviews as DCM. I knew some of the E wing officers better because I would be assigned ACDTs each day and some of the individuals I reviewed would be on the E wing for their observations. There was nothing about him that concerned me.

e) John Connolly: he was a C&R trainer and I had him for refresher training which I did every year. The incident shown in the panorama where John Connolly is in the stairwell prepared for a C&R shocked me because I never witnessed him using derogatory language like that. He was professional, highly regarded and very experienced. On one occasion, I got called in at 2 or 3 am as there was a riot on the external courtyards. They had locked up for the evening and when I arrived, John Connolly was there to oversee and plan the C&R. They would not have called him in if they did not regard him as competent. He was based at Tinsley House as an officer and was only at Brook House for training purposes or a planned C&R. At one point I think he became the head of C&R. They started to have to wear bodycams for C&Rs, and John would be responsible for training and going through all the footage captured on the bodycams.

f) Dave Webb: he was an E wing officer. He was placid and kept himself to himself. Nathan Ward and Dave Webb are brothers in law. I knew him on the same level as I did the other E wing officers to the extent that I only worked with or conversed with them when doing ACDT reviews on the E wing. Other than that, I had no reason to be down there.

g) Clayton Fraser: he was a Tinsley House Officer. They were using some of the Tinsley staff at Brook House because they were that short of staff. Most days, they wanted a couple of officers from Tinsley to come up to Brook House. He was at Tinsley when I was at Brook House, so I never worked with him.

h) Charles Frances – he was an E wing officer. As with As with Dave Webb, he was a smaller, older gentleman. He was not timid but certainly was not aggressive.

i) Aaron Stokes: I cannot remember him.

j) Mark Earl: I cannot remember him.

k) Slim Bassoud: he was an ACO and then become a DCO. I did not work with him much, but he was very softly spoken. I never line managed him because the people I technically worked with and line managed were the ACOs.

l) Sean Sayers: I think he worked in residential as a DCO. I never worked with him. We chatted every now and again as he plays rugby for a team near me, but I never worked with him.

m) Ryan Bromley – he worked in residential and was off sick a lot. I never worked with him.

n) Daniel Small – he was an activities officer and would look after the courtyards, gym etc. I knew him to the same extent as I knew Daniel Lake; I knew him on a day-to day basis but never worked with him directly.

o) Yan Paschall: like Derek Murphy he was an E wing officer, so I only worked with him when I was on the E wing doing ACDT reviews. He had more experience than some of the others. In the E wing, there were 12 rooms and another 6 rooms for temporary confinement which had the bare minimum for someone who was volatile and violent. The individuals on E wing were a lot more volatile, and that is why it had more experienced officers. If a C&R was going to happen, it would happen down there. I was not in the room at the time of the incident with Yan Paschall and the detainee in the Panorama programme and was not aware when it happened. In the few interactions I had with Yan, he was respectful and professional towards detainees. He had been doing the job for a long time and I had never seen him physically or verbally abusive towards anyone.

p) Daniel Lake: I knew him to the same extent as Daniel Small.

q) Babatunde Fagbo: he was one of the ones I worked with the most. Before I was a DCM and I was a DCO, he was on a training course after me. I always got on well with him and he was professional. I witnessed him being called names by black detainees, such as 'bounty', because he was professional and did not go out of his way for them.

r) Shayne Munro/Monroe: I do not remember him.

s) Nurse Jo Buss: she was at Tinsley when I was there. She would often do night shifts and I only worked with her on medical responses when doing ACDT reviews. She would always err on the side of caution with detainees and was professional. I never saw anything which caused me concern about her.

101. During my time at Brook House, I never witnessed any staff, including the above, making derogatory, offensive, or insensitive remarks about individuals which caused me concern. I never witnessed any incidents of verbal or physical abuse and never knew of a complaint from a detainee regarding physical or verbal abuse from staff.

102. The period which the Panorama programme covered was a difficult time for staff because we were under pressure and under resourced. My comments on the program were taken out of context, and I was given no opportunity to explain myself prior to my dismissal. In summary, I do not consider that the content of the documentary is representative of what day to day life was really like at Brook House.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.

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Name	Nathan Dean Ring
Signature	
Date	27 January 2021