BROOK HOUSE INQUIRY

Witness Statement of Stephen Loughton

I provide this statement in response to two requests under Rule 9 of the Inquiry Rules 2006 dated 21 January 2022 (the "**Initial Request**") and 4 February 2022 (the "**Further Request**"). The Inquiry has kindly prepared an initial draft statement based upon my answers to the Initial Request. I have used this draft as a template and include my response to the Further Request at appropriate points below.

The below statement is accurate and true to the best of my knowledge and memory of the period 1 April 2017 – 31 August 2017 (the **'Relevant Period'**). Since receiving the Rule 9 Questions, I have had access to, and the opportunity to review, documentation that relates to the Relevant Period to assist me in providing detail. The documents I have been asked to consider are referenced within this statement.

I, **Stephen Loughton**, will say as follows:

Background

1. My career history is as follows:

    1999 – 2009 – I worked at Gatwick airport as a ground handling agent.
    2009 – I started as a Detainee Custody Officer ("**DCO**") at Brook House.
    2009 – 2010 – I became a Detainee Custody Manager ("**DCM**").
    2018 – I became an E1 grade (the position that is below senior management level, but above the DCM level).

2019 – I was seconded D2 grade (a senior management position which is an equivalent to the Assistant Director Level within Serco).
2020 – I became a permanent Assistant Director.

Culture

2. The culture at Brook House changed over the years. When we first opened we had a lot of new staff and there were teething problems. The teething problems centred around staff being unaccustomed to the environment. Often, new staff were dealing with Time Served Foreign National Offenders ('TSFNOs') that were used to the system and knew it well. Once these teething problems were addressed, the culture improved.

3. I was a manager on the wings and then became an Oscar 1. The culture was fine on the wings, but it did get worse when I became Oscar 1. I feel this was down to staffing levels and the centre being quite full most of the time.

4. At the time, I line managed around 6 – 8 individuals. However, the people that I managed were non-resident facing staff, for example, those who worked on reception or in the gatehouse. I do not recall all of their names. Despite this, I had a lot of contact with resident facing staff, although I did not line manage these individuals.

5. The culture has changed over the period of time that I have worked at Brook House. However, in 2017 there was a big problem with drugs which created a gang culture within Brook House.

6. As to whether I had any concerns about how the culture may have impacted on detainees, I would comment as follows:

a. I felt that those who were detained at Brook House were looked after and I had no concerns about the values of G4S and how they impacted upon residents or staff.

b. There was a lack of managers and staff during the Relevant Period, so managing staff was difficult. At DCM level there were 2 residential managers looking after 2 wings and if staff were off sick, they would be looking after 4 wings at times. In my view, staff were still managed well with yearly reviews. However, this was much harder due to time and the pressures of looking after 2 units instead of 1. We would not only manage staff, but we would also have to manage regular daily incidents that occurred.

c. With regard to especially vulnerable detainees, to the best of my knowledge Assessment Care in Detention and Teamwork's ("**ACDT**") were always done on time and reviewed within 24 hours. We also had access to the healthcare mental health team who were on site daily. I did not have any concerns with this.

7. There was a lack of communication between the Senior Management Team ("**SMT**") and the DCMs and DCOs. The SMT were not visible to staff which often made it feel as though there was a "them and us" culture and that staff were not properly supported. However, if you had an issue that needed raising, you could approach the SMT. In my experience, during the Relevant Period, we would only see the SMT when there was a major incident.

8. I felt at the time that the SMT always stayed in their offices. However, in my current position, I better understand their role and I now know that we did not always understand / appreciate all of the work that the SMT did.

9. It was also difficult for less senior managers, such as DCMs, to engage with DCOs during the Relevant Period as at the time, there was not a DCM rostered to each area. Unlike now, DCMs had to spread their time across different areas of Brook House, sometimes across all of the wings. It often felt that you were being dragged from 'pillar to post', which made it difficult to support our staff.

10. As a DCM it was hard to support DCOs, not through a lack of wanting to, but because we did not have the time to support all their daily tasks. I always tried to support my staff as much as possible, but this could be difficult back then due to the pressures on us.

11. I did not formally report the fact that it was difficult to support DCOs at the time. It was not a secret and was common knowledge within the SMT. However, I am likely to have mentioned it during my yearly development reviews. The situation is far better now due to the increased number of staff available.

12. Staff could progress from DCO to DCM when an opportunity to do so became available. However, they could also progress by gaining more experience in certain areas, for example, becoming control and restraint ("**C&R**") instructors or ACDT assessors.

Training

13. I attended the initial 8-week training course when I started at Brook House in 2009 when the centre opened.

14. When we carried out our training, we were fortunate that the centre had not yet been opened, which gave us the time to adjust to the centre. I feel it was a good intense course covering most aspects of the job and stood us in good stead for when the centre opened. After the centre had opened, any new recruits were trained in the classroom and then put straight into the job which was an 'eye

opener'. When starting on the wings there was no mentoring process in place meaning staff had to get on with the job they had been allocated. There was a shadowing scheme in place, but due to the lack of staff, sometimes this did not take place.

15. The training regime is far better now with an enhanced mentoring and shadowing model. I am involved in some of the training currently provided and try to give all new starters an insight into the centre before they begin their roles, for example, by giving them a tour of the building. When starting at Brook House, I think it is very important that staff receive practical experience. However, this can sometimes be difficult, as new starters are not allowed into resident facing roles until they receive suitable clearance.

16. I received Use of Force ("**UOF**") training in February 2009, which is refreshed annually.

Staff Training

17. I do not recall experiencing or witnessing any racist attitudes amongst staff or towards or in front of residents.

18. I do not recall experiencing or witnessing any homophobic or misogynistic behaviours amongst staff or towards or in front of residents.

19. I was not aware of any staff bringing drugs into Brook House.

20. I did not experience any bullying to my knowledge.

21. I did not have any concerns about staff being bullied at Brook House.

22. I cannot recall dealing with any complaints relating to bullying at Brook House.

Relationships with staff

23. I cannot recall whether I conducted or was witness to any disciplinary action or grievances, save for the ones referred to within this statement.

24. I have been asked to comment upon the allegations made by Michelle Brown within document VER000221, regarding my stag weekend holiday to Magaluf. The comments suggest that 15 people attended, which is incorrect. 9 people attended. One was a member of the SMT and the remaining attendees were DCMs or DCOs.

25. I accept that one member of the group got a G4S tattoo, but I was not directly involved in this and I certainly did not promote it on social media.

26. I accept that alcohol was consumed during the holiday, but to my knowledge, no illicit drugs were taken which appears to be suggested within the document.

27. I live around 1 hour from Brook House, which meant that I did not often socialise with staff. I estimate that I attended social gatherings around 2 / 3 times per year, for example, at Christmas or for someone's leaving party. A mix of staff would attend these events, including DCOs, DCMs and members of the SMT.

28. Attending such events did not affect my working relationships. Many of the individuals I worked with were both my professional colleagues and my friends. I have worked at Brook House for 13 years and if anything, attending social events outside of work improved my working relationships.

29. Reading Michelle Brown's comments shocked me. She appears to suggest that there was a 'laddish culture' within Brook House, which was not my experience. In my opinion, everyone stuck together and supported each other. Michelle herself

was invited on and would attend evenings out and even stag-dos. She has also made a number of comments which I do not consider true, for example, she infers that she was left short staffed as a result of my wedding. This cannot be correct as everyone who attended did so after receiving authorised annual leave. Had there been any concerns about staff numbers, their requests would have been rejected, which was not the case. It was all approved and everyone followed the correct procedure. Michelle was also a guest at my wedding and as I recall stayed in the hotel overnight.

Staffing levels

30. I believe there were around 2 DCOs on the wing during the Relevant Period but in my opinion this was not adequate to enable staff to perform all the functions of the role because I do not believe that 2 officers looking after 120 detainees on a wing could have done the job effectively. There would be no additional resource because the requirement was only 2 officers on a wing.

31. In my opinion the impact this had on staff was that it was mentally draining for them, which was not good for staff morale and safety. There was no real structure to the role and staff morale went down because officers were often doing 13.5 hour shifts, because the majority of the residents at that time needed a lot of assistance from staff. This often meant staff had no breaks.

32. Limited activities were provided where staffing levels allowed.

Treatment of Detained Individuals

33. During the Relevant Period, I was employed as an Oscar 1 which meant that I was involved in a lot of planned UOF incidents. Planned UOF would usually be in place for those who needed escorting to a flight which they did not want to board.

34. I cannot recall every event I was involved in, but my role would be to supervise the intervention.

35. Planned interventions were recorded on a handheld camera which should have been followed by a de-brief. As planned UOF events occurred frequently, I cannot recall if a de-brief occurred after every event. The de-brief would be completed by the supervising officers involved and healthcare would be present.

36. I cannot remember all of the staff or residents involved in each and every use of force incident.

37. I cannot recall any specific lessons learned from C&R incidents that I have been involved in.

38. I was not made aware of any incidents that I was not directly involved in regarding UOF and therefore cannot comment on whether I had any concerns about the actions of others.

39. In my view, throughout my time at Brook House, C&R is always the last option.

40. Before using C&R we would talk to detainees from the door to try and persuade them to comply with what they were being asked. We would give detainees enough opportunity to comply before sending a team in to take control of the situation.

41. C&R would only be the first option if a detainee's health and wellbeing was at risk and force was required to stop them doing something to hurt themselves.

42. If there were any mental health concerns, we would always involve the mental health nurse. DCOs were not mental health trained and could not support detainees with these needs.

43. In my opinion, there were not enough mental health nurses to deal with residents in need and to attend ACDT reviews. This also meant that they did not get around to residents as quickly as we would have hoped due to resource and capacity issues. We would often ended up looking after people we were not trained to look after.

44. I did not raise the lack of mental health nurses with the SMT. Again, it was not a secret and the SMT were aware of the issues, so I did not feel I needed to raise it more formally. However, I am likely to have raised the issue during my yearly development reviews.

45. In my opinion, my approach did not differ towards TSFNOs and non TSFNOs. As the centre was usually quite full we had to locate residents in rooms together. We tried as far as possible to pair up smokers, nationalities, and religions as best we could.

46. There was no plan in place to consider the impact that mixing TSFNOs and non TSFNOs would have on detainees. We were told that we had to fill rooms and would try our best not to mix those that would cause harm to one another. When the centre was full, we were not always able to choose where detainees should be situated and who with, and we had to offer them a room irrespective of where it was. In my opinion this was not the right thing to do.

47. I did not raise this formally with the SMT as once again it was not a secret and the SMT were aware of the issues, so I did not feel I needed to raise it more formally. However, as above, I am likely to have raised the issue during my yearly development reviews. The situation has improved dramatically since Serco took

over Brook House. However, COVID has meant that we have fewer residents, which does makes it easier to accommodate people.

48. I did not witness any verbal or physical abuse of detained persons from staff.

49. In the environment we work in, there is always likely to be some confrontation between residents. If this arose, we tried our best to separate the individuals either by moving them to another wing or opening anti-bullying booklets. I did not have any specific concerns about this area.

50. An anti-bullying booklet is a strategy to manage bullying incidents. It was a document, similar to an ACDT, and there would be one for the victim and one for the alleged bully. If an incident was brought to our attention, we met with both residents separately. We explained the process and the reason for the booklet and staff conducted observations. A review would then take place weekly. If a larger problem arose, we would separate the residents, but would still monitor them. I treated bullying seriously and although not used often, anti-bullying booklets were serious documents.

51. During the Relevant Period I did deal with some complaints from residents as part of my role, but I cannot recall names or incidents.

52. When dealing with complaints, the only involvement I had was the investigation into the incident. I did not see anything further once my investigation had concluded.

53. I did not have any concerns about the complaints process in place during the Relevant Period.

54. To the best of my knowledge, I do not believe I was involved in any Professional Standards Unit ("**PSU**") complaints that were made against myself.

The Panorama Programme

55. I believe I appeared in the programme twice.

56. The first time I was seen on the programme is in relation to the incident on 25 April 2017 (referred to below). The second time I was seen is when I assisted a resident on B-wing onto a chair when he appeared to be under the influence of spice. I do not know the exact time of this second incident.

57. In my opinion, the programme impacted staff negatively and severely reduced staff morale. I recall that a number of staff left Brook House following the release of the programme which made the staffing issue even worse in the short term.

58. When I came back to work after Panorama had aired, everyone was shocked. Despite staff members working long hours and putting themselves at risk to help others, footage like that on the programme painted all staff in the same light. Staff were under immense stress and dealt with problematic residents on a daily basis. However, despite this, there was so much good work undertaken at Brook House, which outweighed all of the negative events witnessed on the programme. I accept that Brook House was not a great place to work, but this was not down to the staff. Staff could only do what they could with the resources provided. The footage did not show any of the good work carried out by staff.

59. I was made aware that staff had received messages on social media from people telling them that they should be ashamed of themselves. This negatively affected staff and the ridicule and mimicking that they were subject to left staff at 'rock bottom'.

60. I feel that the Panorama programme could not have been further away from what actually happened on a day to day basis. Had we been given the opportunity to show all of the positives at Brook House, or all of the thank you letters we received from residents, I am sure that a different picture would have been painted.

61. There were a lot of changes at Brook House following Panorama which were effective immediately. One of the changes I can remember was an increase in staffing levels. Numerous policies and procedures were introduced to improve safeguarding too.

62. Following Panorama, the last two years of G4S running Brook House were much better. However, I cannot pinpoint exactly what made it feel better.

63. Following the Panorama programme some individuals who worked at Brook House were either investigated, disciplined, dismissed or left. I worked with those listed below:

    a. Nathan Ring - he was my shift partner and I also car shared with him. I did not have any concerns about Nathan's personal views or behaviours, nor did I witness any verbal or physical abuse from Nathan.

    b. Steve Webb - he was a residential DCM, so I worked alongside him. I did not have any concerns about Steve's personal views or behaviours, nor did I witness any verbal or physical abuse from Steve.

    c. Chris Donnelly - he was also an Oscar 1 so I worked alongside him. I did not have any concerns about Chris' personal views or behaviours, nor did I witness any verbal or physical abuse from Chris.

d. Kalvin Sanders - he was a DCO and I didn't work with him much. When I did, I did not have any concerns about Kalvin's personal views or behaviours, nor did I witness any verbal or physical abuse from Kalvin.

e. Derek Murphy - he was a DCO that worked on Eden wing. I had a lot of dealings with him as I spent a lot of time on Eden Wing. I did not have any concerns about Derek's personal views or behaviours, nor did I witness any verbal or physical abuse from Derek.

f. John Connelly - he was a C&R Instructor but worked mainly at Tinsley House. I did not have any concerns about John's personal views or behaviours, nor did I witness any verbal or physical abuse from John.

g. Dave Webb - he was a DCO that worked on Eden Wing, I had a lot of dealings with him as I spent a lot of time on Eden Wing. I did not have any concerns about Dave's personal views or behaviours, nor did I witness any verbal or physical abuse from Dave.

h. Clayton Fraser - he was a DCO and I believe he was based at Tinsley. I did not have any concerns about Clayton's personal views or behaviours, nor did I witness any verbal or physical abuse from Clayton.

i. Charles Francis - he was a DCO that worked on Eden wing. I had a lot of dealings with him as I spent a lot of time on Eden Wing. I did not have any concerns about Charles' personal views or behaviours, nor did I witness any verbal or physical abuse from Charles.

j. Aaron Stokes - I think he was a DCO, but I can't remember having any dealings with him.

k. Mark Earl - I think he was a DCO, but I can't remember having any dealings with him.

l. Slim Bassoud - He was a DCO. I had a few dealings with him. I did not have any concerns about Slim's personal views or behaviours, nor did I witness any verbal or physical abuse from Slim.

m. Sean Sayers – he was a DCO that worked on a residential wing, I did not have many dealings with him but when I did, I did not have any concerns about Sean's personal views or behaviours, nor did I witness any verbal or physical abuse from Sean.

n. Ryan Bromley- he was a DCO that worked on a residential wing. I did not have many dealings with him but when I did, I did not have any concerns about Ryan's personal views or behaviours, nor did I witness any verbal or physical abuse from Ryan.

o. Daniel Small – he was a DCO who worked in activities. I did not have many dealings with him but when I did, I did not have any concerns about Daniel's personal views or behaviours, nor did I witness any verbal or physical abuse from Daniel.

p. Yan Paschali – he was a DCO who worked on Eden Wing. I had a lot of dealings with him. I did not have any concerns about Yan's personal views or behaviours, nor did I witness any verbal or physical abuse from Yan.

q. Daniel Lake – he was a DCO who worked in activities. I did not have many dealings with him but when I did, I did not have any concerns about Daniel's personal views or behaviours, nor did I witness any verbal or physical abuse from Daniel.

r. Babatunde Fagbo - he was a DCO and I believe he worked on the wings. I did not have many dealings with him but when I did, I did not have any concerns about Babatunde's personal views or behaviours, nor did I witness any verbal or physical abuse from Babatunde.

s. Shayne Munroe - I do not recall this officer at all.

t. Jo Buss – she was part of Healthcare. I remember who she was but did not have many dealings with her. When I did, I did not have any concerns about Jo's personal views or behaviours, nor did I witness any verbal or physical abuse from Jo.

64. During the Relevant Period I was an Oscar 1, which meant I was the Duty Operations Manager for the whole centre. My role meant that I spent a lot of time on Eden Wing and the care and separation unit ("**CSU**"), as I dealt with residents on Rule 40 or constant supervisions a lot of the time.

65. I cannot recall any incidents of any staff using verbal or physical abuse at any time. Nor did I witness any derogatory or offensive remarks from any members of staff.

Protest on 14 April 2017

66. I do not recall this specific incident and reading the documents has not assisted in refreshing my memory.

67. In relation to protests, there were contingencies in place. These would be run from the command suite if it was opened. During incidents like protests, safety is always the main priority. If the situation warranted it, this might involve removing staff from the vicinity and deploying negotiators.

68. Protests occurred from time to time over the years and Oscar 1s were experienced in dealing with such incidents.

Incident on 25 April 2017

69. I recall this incident. With regard to the Inquiry's initial question, D1527 was not located in the CSU. He was located on E-wing where we have two rooms (rooms 7 and 8) which we use for constant supervision. These two rooms are designed to allow for better observation, for example, the viewing panels can be extended and the room is structured in a different manner which makes it easier to view. I believe that D1527 was on constant supervision at the time of the incident, rather than an ACDT.

70. At the time, I was completing my rounds when I came onto E-wing. I saw an officer standing by the door to D1527's room looking inside. He stated that he had not seen the resident for a few minutes so I immediately went inside, whereupon I saw D1527 with a ligature around his neck. I removed the ligature using a fish knife and attempted to sit D1527 on his bed. He was conscious and breathing. D1527 then became irate and I believe that it was at this point that he placed a battery inside his mouth. I do not recall whether I saw D1527 remove the battery from his mouth, but I do not believe that I would have left the room had I thought the battery was still in his mouth. That would have been my practice in this scenario.

71. By this point, a number of staff members had attended the scene, including healthcare staff. I was a little shaken by the incident, so I handed the matter over to another DCM and those attending, so I could complete my UOF paperwork.

72. My report (document CJS005534) does not refer to the battery as such reports are solely focused on force. That is why the battery is not mentioned. Only individuals who use force are required to complete a UOF report. I do not recall that any other

staff used force during this initial incident, so they would not have needed to complete a UOF report. They may, however, have completed other forms.

73. I do not recall updating any other records. You would not need to complete an SIR as that is a different form. In hindsight, I might have updated an ACDT review. However, because D1527 was already on the highest level of supervision, had an ACDT been updated, he would have simply remained on constant supervision, which was being reviewed in any event.

74. Where I refer to the UOF paperwork and the fact that it 'could be a late one', this is in relation to the fact that I was required to complete my reports. UOF reports should be completed within 24 hours and I always preferred to deal with such tasks as soon as possible. It may be that I was not at work on 26 April 2017, so I would have had to work late to complete all the paperwork in accordance with required timescales. This explains why I made those comments.

75. My use of the words "... a battery in his mouth, the cock", is regrettable and I would agree that it is inappropriate language. I can only imagine that at the time I was a little shaken up having just removed a ligature from D1527's throat. I may have been in shock and had lots of adrenaline running through me. Whilst that does not condone my use of inappropriate language, I am sure that I made those comments whilst I was leaving the room. I would certainly never speak directly to a resident like that.

76. I do not recall Nathan Ring stating "Going all night, Duracell bunny isn't he" and "He's just a dick". There were a number of people in the vicinity and lots of talking and shouting. This meant that I would not have been able to hear everything that was said. Whilst the language may appear clear on body camera footage, it is unlikely to have been audible for everyone in the area.

77. My reference to D1527 "sulking" may have been a reference to his demeanour. D1527 had gone from very aggressive to sitting quietly. It was not a pejorative word to use and was simply an accurate description of how he was presenting at the time. It was not intended to be derogatory.

78. I do not recall my interactions with staff members following the initial incident on 25 April 2017. After handing over the incident, I returned to the Oscar 1 office to complete my report. This is located in the centre of Brook House.

79. If a detainee attempts to self-harm again, the correct action to take would depend on the type of self-harm being used. Sometimes you may be required to use force to prevent self-harm, or to keep a resident on constant watch until an appropriate time. A resident would not be left alone after a self-harm incident until staff were confident that he had calmed down and there was limited risk of reoccurrence.

80. I have been asked to comment on whether I was aware of officers sitting down to write a report. From my experience, ideally officers involved in incidents would be replaced so they could go somewhere quiet to write their report. This might have been in the office, or somewhere else later in the day.

81. I am not aware of any situations where someone removed a UOF report from the pigeonhole.

82. If I am notified that force has been used during an incident, part of my job is to ensure that those who have used force complete a report. I am not aware of any instances where UOF reports were not completed.

83. I am shocked by Yan Paschali's comments in document SXP000120 regarding his time as a prison officer. I had never heard those comments before and they are certainly not right. I have never heard or witnessed anything like that occurring at

Brook House. My experience of Yan was that he was a calm person and the conduct that I witnessed never suggested that he would do something like that.

84. I have never witnessed or experienced senior staff ignoring the actions of officers. Personally, I have never ignored the actions of DCOs or DCMs.

85. The reference to 'Nobby' in TRN0000099 is a reference to me. However, I do not recall that I was in a bad mood about the incident on 25 April 2017. I was perhaps frustrated by the fact that a member of staff on constant watch waited many minutes before entering D1527's room after they had lost sight of the detainee. If you are tasked with watching someone, you should take appropriate action when you cannot see them. I was perhaps also frustrated from a safeguarding perspective, as it should not have got to a point where a resident could place a ligature around his neck. I take my role very seriously and this incident should have been acted upon earlier.

86. I do not have any further comments on the KENCOV1007 V2017042500020 footage, save that the resident should not have been able to get into a position where he could place a ligature around his neck like that. He should have been stopped earlier.

87. Whilst I was not there at the time of the KENCOV1007 V2017042500021 footage, I am shocked by it. It should not have happened.

Incident on 27 May 2017

88. I do not know who assigned the roles for this UOF. I believe that DCM Dix was the supervisor for this planned intervention, so he may have chosen the team. However, when planning a UOF, supervisors could call the Control Room to request officers to collect their kit. If this second option was chosen, there would not be a selection process per se.

89. A shield is used as part of a team's PPE during all planned interventions. Three officers would go into the room first in an arrow formation. The first officer would carry the shield and place it over the detainee to control them. This is to protect the resident and the officers involved, for example, from weapons. As soon as other officers had taken control of the resident, the shield would be removed. It was not used throughout.

90. Prior to any planned intervention a briefing would take place with those involved in the UOF, including healthcare. As part of this briefing, staff would state whether they were 'in ticket' and whether they had any injuries. If someone was not capable of fulfilling the role assigned to them, this could be confirmed during the briefing.

91. I was not aware that Callum Tulley had concerns about the use of the shield in this incident.

92. I do not recall hearing the comment made by DCO Webb ("if he dies he dies").

93. Where I refer to Yan Paschali pushing Callum Tulley, this was a reference to supporting Callum as he entered the room. Having reviewed the transcript, I can see that the team were reassuring Callum of what to do with the shield. The shield role is important during a planned intervention, so if Callum did not go into the room with purpose, the two officers behind him (in the arrow formation) would have followed him up to ensure that he was not on his own. This is what I meant by pushing Callum into the resident. It was to ensure that the shield was applied in the correct manner to control the resident.

94. I do not wish to add any further comments in relation to this incident. The incident took place a long time ago and I was involved in many C&Rs, so I do not recall it in detail.

Incident on 21 May 2017

95. I do not recall this incident and reviewing the documents has not refreshed my memory. Therefore, I am unable to answer the Inquiry's questions about it.

Incident on 6 June 2017

96. [Blank]

Conversation on 14 June 2017

97. I do not consider the use of the words “knob head” and "arsehole” appropriate and my use of language is regrettable. There is no excuse for that, but I am sure that I did not make the comment to the resident's face. I would not do that. I was probably frustrated by the situation, as I was trying to help the resident. I let out my frustration in a way which, in hindsight, was inappropriate.

98. There was not a culture of referring to residents in this manner.

Conversation regarding a headlock on 15 June 2017

99. I do not recall the alleged incident involving a member of healthcare staff placing a detainee into a headlock. I do not recall healthcare staff ever using force like that. Similarly, I do not know anyone called Chris from New Zealand, so I am not sure what this transcript relates to.

Facebook comment regarding Callum Tulley

100. I have reviewed document INQ0000001 and I believe that I am the person who made this comment on Facebook. I do not know when it was made, but it was

probably shortly after the Panorama programme aired. I do not usually use social media, so I can only imagine that I made the comment in anger.

101. I was possibly angry because Callum Tulley had been portrayed as an 'angel' who people felt sorry for, when in fact, my experience working with him was very much the opposite. I expect that this is why I called him 'fake'. I believe that he had been manipulated by reporters who asked him to find evidence wherever he could. Throughout my time at Brook House, I always wondered why Callum appeared at incidents which he should not have attended, for example, because he was not part of the first response team. I now understand that he did this to covertly record as many incidents as possible.

102. There is no doubt that some of the events shown within Panorama were absolutely wrong. However, Callum's responses throughout the programme did not accord with my perception of working with him.

Allegation regarding DCO Sayers

103. As an Oscar 1, during a shift I would conduct all of my checks, for example, on keys, radios etc. I would then visit every part of the centre, including the gatehouse and reception. During these rounds, I would speak to staff to ensure that everything was as it should be. These checks were conducted periodically as I also had my own work to complete, including preparation for the following day.

104. Residents on constant watch would be observed by a member of staff. This would usually be rotated in hourly shifts on a timetable. If, for example, a staff member needed to go to the toilet, they could radio a colleague to relieve them, or call to a colleague who would be based on their wing.

105. I do not recall ever seeing DCO Sayers being asleep whilst working.

Incident on 11 June 2017

106. I disagree with the conclusions reached in document CJS005937 and I do not recall receiving any advice following the investigation.

107. I disagree with the conclusion as I do not think that what I said was wrong. There was no malice in my comments and I had built a good rapport with D368 over many years, so I knew the most appropriate manner to speak to him. My comments were made in a friendly and familiar tone.

Other disciplinary processes

108. [blank]

109. If I received a report about an incident I might be asked to conduct a fact finding exercise. I would interview relevant staff and provide my notes to the SMT. I do not recall being involved in many of these in the past. I do not recall the specific processes, but I believe that if you were involved in the fact finding element of the process, you would not be involved in the disciplinary.

110. I do not know what incident the Inquiry is referring to in 2018. However, I have received disciplinary sanctions for leaving doors open in the past. On one occasion, I received a final written warning which has now lapsed.

Other matters

111. In my opinion we were understaffed, and everyone looked after each other and they did an amazing job under the circumstances they were in. Staffing levels will and have improved the health, safety and welfare of residents.

112. There were not enough activities for residents and they were often bored. In my opinion, this is why a greater number of incidents occurred. However, this has improved significantly since the Panorama programme.

6th June 2017 incident

113. I have reviewed documents CJS005615, HOM004133 and have now been provided with footage KENCOV1031: V20170606000011. Having reviewed the footage I can clearly recall the incident in question. I was the Oscar 1 at the time of the incident and responded to an urgent response call. I was not personally involved in the Use of Force shown on the footage and I cannot recall it taking place. My role as Oscar 1 would have been to look at the bigger picture. As the other officers were dealing with the resident, I would have been in the vicinity of the room ensuring that people were moved along, clearing the area and ensuring that there was a free route to E-wing/CSU. My main priority at that time would have been moving the resident from the room and clearing the space to ensure that the area was safe and secure. I would have been thinking about next steps to ensure the safety of the resident and the officers involved.

114. During incidents like this, it is not always possible to immediately establish what has occurred. Whilst in this case it is clear that the resident was attacked, I would not have known that having just entered the room and I would not know what led to the assault. Therefore, I believe the resident was moved to E-wing initially to ensure that he was in a safe environment. This allowed staff to review the CCTV footage to establish what had occurred. Had there been some form of provocation which warranted action, we might have moved the resident to the CSU (which is an easy relocation from E-wing). However, that does not appear relevant in this case.

115. I believe that I was in the vicinity of the restraint used on D1538, but I do not recall seeing it take place.

116. The documentation shows that I signed off on the cause of force form concluding that "minimum force was used on D1538 to prevent any further assault". In order to reach this conclusion, I or other managers would have reviewed the reports and viewed CCTV footage. In this case, I consider that minimum force was use. Shane Farrell took control of the resident's head. He did not use excessive force in doing so. It was necessary and proportionate in the circumstances.

117. In my view, the force used by DCM Shane Farrell was appropriate. Using force in order to prevent the resident's head from hitting a cabinet or hurting officers is a legitimate reason for using force.

118. I did not hear Ryan Bromley use the words 'took his head clean off' and having reviewed the footage, I do not believe that that is a fair description of what actually occurred. I do not know why the incident was referred to in this manner. In my view, minimal force was used and it was necessary and proportionate.

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.	
Name	Steve Loughton
Signature	**Signature**
Date	18th February 2022