BROOK HOUSE INQUIRY

First Witness Statement of Sean Sayers

I provide this statement in response to two requests under Rule 9 of the Inquiry Rules 2006 dated 5 July 2021 and 4 November 2021.

I, Sean Sayers, (D/O/B **DPA**, will say as follows:

Introduction

1. I have been asked to provide a witness statement to the Inquiry as a result of the position I held previously as a G4S Custodial and Detention Officer (DCO). I am no longer employed by G4S and give this statement in a personal capacity.

Background

2. I was employed by G4S at Brook House from September 2016 to November 2017 as a Detention Custody Officer (DCO). Prior to my employment at Brook House, I was a door security supervisor for 8 years. In order to get my door supervisor licence from the Security Industry Authority (SIA), I undertook an NVQ Level 2 qualification. I was dismissed from Brook House after the Home Office revoked my certification on 3 November 2017, following the broadcast of the Panorama programme. My current employment is installing timber buildings.

Application Process

3. I have always wanted to work in the prison service but unfortunately I failed the maths exam, which is necessary for the role. Working at Brook House was very similar to being a prison officer, except that you were dealing with detainees rather than prisoners. It was a challenging role but I really enjoyed it; I had a good rapport with most of the detainees and enjoyed helping people.

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4. It was very difficult for the recruitment process to adequately prepare you for the role. We were told about the kinds of things that we would be dealing with, but the reality is very difficult to prepare for. For example, we were told that we may have to cut someone down who is trying to commit suicide; the reality was that this happened more often than we were led to believe. I had worked as a door supervisor for 8 years, so had had conflict training and a lot of experience in managing conflict situations. However, there were a lot of new recruits who were straight out of school or university, and many of them did not last very long on the wings.

Culture

- 5. There was a good camaraderie between many of the DCOs. The attitude from management towards DCOs was kind of 'suck it up and get on with it' not much care was shown towards officers. Some of the Detainee Custody Managers (DCM)s were really good and supportive but this seemed to be down to them as individuals rather than as a result of the management culture.
- 6. When my cohort finished our training we were excited to be there and to begin working on the wings. However, it quickly became clear that the reality of the work was going to be very different to what we had expected. The main reason for this was the constant staff shortages which put the staff under a lot of pressure every day. There was also a very high turnover of staff. These factors had a very damaging effect on morale.
- 7. On the whole staff at Brook House displayed a fair attitude towards detained persons. Often we did not have adequate staff numbers to deal with any problems so we tried to avoid conflict as far as possible by keeping detainees happy. I am not sure who was responsible for the decisions regarding the numbers of officers on the wings but in my view it was not safe. Although Brook House was run like a prison, it was different in that you had former prisoners housed alongside vulnerable individuals, often 3 to a room. Unlike a prison, detainees had access to everything they would need to cause themselves or others harm. We did not have

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the numbers of staff to monitor every situation on the wing. The management of staff was an impossible task from a DCM's point of view because of the low numbers of officers and managers. Officers would need to be pulled off their wings/departments to cover shortages, breaks, staff sickness or hospital escorts. There were some days when we would not even see a manager, which is no

criticism of them; they were also completely stretched.

8. I did not have any dealings with senior management so cannot comment on their values or priorities. The most senior person I had any dealings with would be a

DCM.

9. I am not aware of any occasion where someone raised any concerns about the treatment of detained persons either individually or collectively by staff.

Physical Layout of Brook House

10. My only comments regarding the physical layout of Brook House is that, while

the centre was not a prison, it strongly resembled a prison in its layout and set up.

I do not think much could be done to improve the layout of Brook House;

however, more officers on the wings and fewer detainees (so that they do not

share 3 to a room) would improve the care of individuals detained at Brook

House.

11. E wing was used to house and monitor vulnerable detainees, for example, those

who had committed or were at risk of self-harm. It was also used to house people

who had been put on a Rule 40 (removal from association order) for

misbehaviour. Detainees would also be sent there prior to planned removals. The

wing was smaller but had the same number of staff as the larger wings, so it was

easier to monitor individual detainees. Those who required constant supervision

would be monitored by staff members who were pulled off other

wings/departments to cover that. Otherwise E wing was the same as the others

wings. I did not work on E wing so I am not aware of the criteria for moving

detainees back to the regular wings.

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Policies and Procedures

12. The policies and procedures governing our work at Brook House were explained to us during a detailed 8 week training course, which included a number of power point sessions. I believe we were also given copies to keep in our personal folders. I do not recall the policies being updated during my time at Brook House.

Training

13. I spent the first 8 weeks of my employment undertaking the training course. The training covered C&R, first aid and included power point sessions on various other topics from what I can recall. I also undertook personal protection training. I found the training to be very thorough and comprehensive, but there is a limit to what can be taught in a classroom. We were supposed to do 2 weeks shadowing but that did not happen as there was a shortage of staff on the wings so we went straight to work there following the training. I was not at Brook House long enough to be sent on any refresher training.

The role of a DCO and relationships with detained persons

- 14. The job description [CJS004294] accurately summarises the roles and responsibilities of a DCO. I had a good rapport with most of the detainees on my wing. I made a point of being friendly towards detainees as I found that this was the best way to avoid any conflict and ensure the shift was a smooth as possible. All the issues I had to deal with (for example, responding to conflicts or incidents) tended to come from other wings, and I would be called to assist. There was a language barrier with some detainees but we were able to utilise interpreters on the telephone; sometimes it might be difficult to get hold of someone, but once you did, it worked very well.
- 15. The only incentive for detainees for good behaviour was to get paid work. The servery was popular, as it got detainees out of their cell for the longest. Other than that there was nothing to encourage good behaviour. It is difficult to think of suggestions for what could have been offered.

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to carry out observations on that person at the specified times, for example, every 4 hours, and log it on the form. If a DCO was concerned about someone we could also open an ACDT with a manager's approval. In theory this process was a good

16. If a detainee was placed on an ACDT, it would be the role of a DCO on the wing

one, but in reality we did not have enough staff to carry out observations on top of

managing the wings. This put staff under immense pressure and there would be

times when observations would be delayed.

17. There were a number of measures used at Brook House to prevent drugs from

entering. These included random searches of cells and detainees, scanning post

and searching/scanning visitors. Unfortunately these measures did not work and

drugs seemed to find their way onto the wings. The most commonly used drug

was Spice. I am not aware of what would happen to a detainee or staff member

caught bringing drugs into Brook House, as I do not recall ever hearing about this

happening.

18. I did not work as part of the security team or the welfare team.

Relationships with staff

19. I did not witness any racist, homophobic or misogynistic attitudes or behaviours

towards detainees by staff. Neither did I experience or witness any bullying, or

have concerns about any member of staff being bullied.

20. I did not have many dealings with Home Office (**HO**) staff whilst working at

Brook House. I would often hear complaints from detainees that there was no one

from the HO available to speak to them regarding their bail hearings, whether they

were being released, their status and so on. This was a massive source of

frustration to them as it seemed like they could never get a straight answer, which

really affected detainees' moods. This in turn caused problems with officers as we

were the most visible authority figures to them and they did not understand the

separation between us and the HO.

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- 21. My direct line manager was DCM Steve Dix. I had a really good relationship with him and found him to be supportive; any issue I had I would take straight to him and he would do his best to sort it out. I did not have any dealings with anyone more senior than a DCM.
- 22. I had a good working relationship with most other DCOs. I felt confident if I knew I was working with experienced officers that we could manage the wing and have a shift without incident. However, there were many times when I would be working alongside very new and inexperienced officers, and those shifts were always more challenging.
- 23. My main experience of healthcare on a day to day basis was during medication time. This was a difficult time on the wing because healthcare could be quite slow in handing out medications, which caused delays on the wing. We did not have any involvement in the management of detainees' ongoing medical needs and, as officers, we were not given any information about that by healthcare. The other situation in which I would come across healthcare was during planned removals requiring force to be used (referred to as control and restraint (C&R)), as they would always be present in order to ensure that they were happy the detainees were not experiencing any medical issues or were unsafe. It was reassuring to have their presence and know that they could call off a C&R if they felt it was not appropriate.
- 24. Other than the investigation following the Panorama programme (see para 40) I had no involvement in any disciplinary or grievance investigation, either into my own conduct or as a witness

Staffing levels

25. Staff shortages were a daily issue and had a big impact on the care and treatment of detainees. Officers would be taken off the wings to cover other shortages, for example, to accompany detainees on hospital escorts, or to carry out a constant watch on E wing. The wings were often left very short staffed, which meant we

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could not observe what was happening on the wing, or prevent any issues form occurring. This made it more likely that any small issue between detainees would

occurring. This made it more likely that any small issue between detainees would

escalate into a more serious conflict requiring First Response – the team of

officers assigned to deal with any issues requiring urgent assistance on any given

day – to attend.

26. The ongoing staff shortages were terrible for morale as they created a very

stressful working environment in which officers never fully felt safe. There were

100 to 120 detainees to 1 or 2 officers on the wing, so there was always the

potential for disorder as we were so outnumbered. I believe the staff shortages

existed throughout Brook House but am unable to comment specifically on other

teams.

27. I do not recall working alongside anyone from Tinsley House. My recollection is

that Tinsley House staff did not want to come and cover shortages at Brook

House, as it was a much tougher environment than they were used to. Many Brook

House staff wanted to transfer to Tinsley House.

Treatment of Detained Persons

28. I did not work on reception for detained persons or in the induction wing.

29. The activities programme provided detainees with something to keep them

occupied, and did boost morale. It included the gym, the library, the courtyards

and equipment for football and cricket. Occasionally there would be one off

tournaments. If an activity was cancelled or postponed, it would lead to problems

on the wing. In my opinion there was a good range of activities taking into

account the space that was available.

30. I had no involvement with the Rule 35 process and cannot recall what it was.

31. I do not recall receiving any training regarding the mental health of detained

individuals. There were a lot of detainees at Brook House with mental health

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issues, which would lead to incidents of self-harm or acts of violence. If someone was exhibiting these behaviours they would be placed on an ACDT and monitored on E wing. I am not aware of how their conditions were managed by healthcare as officers were not involved in this.

- 32. Policies aimed at preventing drugs from entering Brook House were not successful (see para 17). Drugs, in particular Spice, had a significant impact on the welfare of many detainees who used it; their behaviour would become very erratic, they may begin shouting and they would often go completely limp, requiring urgent medical attention. I am not aware of any drug rehabilitation programme being available at Brook House.
- 33. The Chaplaincy was responsible for providing religious or emotional support to detainees. I do not recall any of the chaplains raising concerns with me about any individual detainee.
- 34. When an individual self-harmed or went on hunger strike, they would be put on an ACDT and transferred to E wing where they could be monitored more closely. If the self-harm was serious enough to require attendance at hospital, an ambulance would be called. The detainee would be monitored and efforts would be made to assist, so far as possible, with any other issues that might be causing the behaviour, for example, if they had been unable to speak to the HO about an upcoming bail hearing, or to their family.
- 35. I did not work on reception for time served foreign national offenders (**TSFNOs**). We would not routinely be told of the reason for a detainee's detention, so we did not know which prisoners were TSNFOs unless we were told by the detainee themselves or other members of staff. In many cases detainees would be very open about the reason for their detention. The co-location of TSFNOs and other detained persons created the potential for more vulnerable detainees to be exploited, and it was very difficult to monitor due to the high ratio of detainees to staff.

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- 36. During my time at Brook House, I did not witness any abuse of any detainee, either physical or verbal, by any member of staff. There would be issues and fights between detainees all the time; to provide an extreme example, I recall there being an incident in which a detainee poured a kettle of boiling water with sugar over another detainee's back as a result of a £10 Spice debt. We did not have enough eyes on the ground and I am sure there were far more conflicts and disputes going on than we were aware of.
- 37. I cannot recall the details of the complaints process for detainees reporting mistreatment. Detainees would often complain verbally to officers about a range of issues, and these complaints would be passed to management. I believe detainees could also make a complaint directly to the HO, but am unable to recall any further details relating to this. Please see paragraphs 62-70 regarding investigations carried out into my conduct as a result of complaints made by detainees.

The Panorama Programme and Disciplinary Proceedings

- 38. I worked with Callum Tully during the entire period I was employed at Brook House. I believe I appear in the programme at 3:35 and 34:15. I was suspended as soon as the programme aired, and was dismissed shortly afterwards, so I am not able to comment on the impact the programme had on staff morale or on those detained at Brook House. For the same reason I have no knowledge of any changes implemented following the Panorama programme.
- 39. I received a letter from the BBC setting out the allegations against me that would appear in the programme. I do not recall when I received this letter but it is dated 23 August 2017. I did not respond to the letter.
- 40. After the programme was broadcast, I was subject to an investigation by G4S [CJS005937]. Two allegations against me were partly upheld and I was subsequently dismissed. I found the investigation to be a fair process. I accept that I used an unapproved use of force technique and that I failed to file a use of force

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report. I do not accept that I lied about this incident and I maintain that the account I gave in the interview was a truthful account.

41. I confirm I was not involved in, or aware of, any disputed age case during my time at Brook House.

Specific Individuals

42. I worked with all of the named individuals. I did not witness any incidents or physical or verbal abuse by any of them towards detainees and did not have any concerns with regard to their personal views/behaviours. I do not have any further comments to make in relation to these individuals.

Alleged sleeping whilst on duty 15 June 2017

43. The BBC alleged that on 15 June 2017 I was seen to be asleep on E wing [BBC000025]. An investigation carried out by G4S found the allegation to be unsubstantiated. I have no comment to make in relation to this incident other than to confirm I do not recall ever falling asleep on shift and deny that this incident took place. I have no recollection of a conversation with DCO Tulley about falling asleep during a shift [CPS000025]. Prior to receiving the letter from the BBC [BBC000025], no one had ever made any such allegation against me. The shifts were long – up to 13.5 hours – and could be considerably longer if there were delays in locking detainees up for the evening. I do not recall the exact break pattern, but I believe we had a 45 minute lunch break and a further short break. We were given time in lieu where we worked extra hours, but it was not really possible to take it. Officers were definitely tired, and in some cases that may have led to a lack of concentration; however, I do not believe that I would ever have fallen asleep on shift.

Use of Force

44. I was often selected to be involved in planned uses of force because I am a big guy and had prior experience of using force in conflict situations in my previous role

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as a door security supervisor. It was a kind of unwritten rule that you could not refuse to be involved in using force if you had been selected. I certainly did not volunteer myself to be involved as was used much more frequently than I would have liked. I do not believe C&R was used excessively at Brook House. Sadly there was no other option where a detainee refused to leave their cell to be deported. No officers wanted to be involved in a C&R so we would always try to talk the detainee round first.

Incident involving detained person D1234 on 28 March 2017

- 45. I have reviewed the footage of this incident and consider the summary of the footage at HOM002485 to be an accurate summary. I have reviewed my account of the incident at HOM002496 and HOM002498 and I do not wish to add to, amend or clarify that account. The detainee was shouting during the entire incident, but he did not complain of any specific pain; I was of course aware that the detainee was uncomfortable as he was being restrained, but he did not complain of being in pain (see HOM002498, para 25). The detainee had stripped naked so we kept a sheet covering him the entire time to protect his dignity. As I state in my report, I wrapped my arms around D1234's legs and locked my fingers together [HOM002496, pages 12-13]; this was an approved technique that we were taught to use where we needed to control a person's legs. As stated in the interview report [HOM002498, para 13] it was necessary for me to anchor myself by putting my feet underneath against the wall and the doorframe. When I had moved to being head officer, D1234 was kicking out in front – I am not sure whether he was trying to kick me or just to kick out in front of himself as part of his resistance to the restraint. I believe that is what DCO Rowley refers to in his report of the incident [HOM002496, page 23].
- 46. I am asked to comment on the conclusion of the PSU that the handcuff carry was not carried out to a taught standard [HOM002750]. We carried out the handcuff carry as we were taught to do so, so this would be a problem with the training we received.

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47. This was a planned removal in order to hand the detainee to the Tascor team who were responsible for escorting the detainee to the airport for removal on a charter flight. It was a challenging situation due to the detainee's resistance, his shouting throughout and the fact that he had removed his clothing. However, I believe the level of force used was necessary and proportionate. I am asked to comment on the appropriateness of forcibly removing D1234 in circumstances when he was naked and chanting on his bed. The timing of removals is not something officers had any control of; if someone was scheduled to be deported on a particular flight, we had no choice but to facilitate that removal.

48. The PSU investigation into this incident was clear and thorough, and caused me no concerns.

Incident involving detained persons D1103, D2497 and D523 on 14 April 2017

49. I have reviewed my report of an incident on 14 April 2017 [CJS005547, p9]. There are no further details that I wish to add to this account.

50. I have also reviewed my report of a separate use of force incident on 14 April 2017, together with the accounts of DCOs Shadbolt and Murphy [CJS005559]. These accounts accord with my memory of the incident and I have no further details to add.

51. I have reviewed my account of a further use of force to remove D523 to the care and separation unit (CSU) after his involvement in the protest [CJS005614].

Although I recall the protest, I have no recollection of this incident and am unable to make any comment in relation to it. Unfortunately I do not recall whether it was myself or DCO Wright who carried out the search of the detainee, although I have no reason to doubt my contemporaneous account.

52. On the same day it is recorded that I intervened during an altercation between DCO Bromley and D1103 in order to protect DCO Bromley from coming to harm [CJS005537]. My recollection is that we were severely outnumbered during the

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protest and were focused on protecting ourselves and our colleagues who had come under attack. The report indicates that DCO Bromley pushed D1103 off himself giving me and DCO Shadbolt time to take him away from the area [CJS005537, p11]. As I did not use any force, I would not have completed a use of force report in relation to this specific incident.

53. In general, I would characterise the force used in relation to the protest on 14

April 2017 as necessary and proportionate to the risk. The wing housed 100-120

detainees, and there was mass disorder. We had a maximum of 12 officers able to respond. It was necessary to get the wing under control as quickly as possible and ensure any officers or detainees did not come to harm. The decision to place detainees on a Rule 40 (removal from association order) and relocate them to the CSU would have been made by management and it was not within our remit as officers to have an opinion on or challenge those decisions. We would always try to de-escalate a situation by talking to the detainee(s) to see if we can reach agreement, but I recall that the situation was very volatile on that day and we had no choice but to regain control of the wing.

Incident involving detained persons D2603 and D1274 on 24 April 2017

54. I have reviewed my report in relation to an incident on 24 April 2017 [CJS005558]. There is nothing I wish to add to this account. I do not recall who told me that D2603 had a bladed article but I believe it would have been the other detainee involved in the altercation, D1274. Following the search, I would have informed the DCM that it had been alleged that D2603 had a blade and he would have made any decision regarding further action to be taken. I do not recall precisely what action was taken in this case. Having reviewed footage of the incident [Disk 36 24042017 0846.mp4, 00:45-01:25, 02:07-12:18] I would characterise the level of force used as reasonable and proportionate in order to stop the two detainees from causing each other injury.

Incident involving detained person D68 on 29 April 2017

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55. I do not wish to add anything to my account of the incident on 29 April 2017 involving D68 contained in my contemporaneous report [CJS005599]. This was a spontaneous and pre-emptive use of force in order to protect myself from attack. I consider the level of force used was reasonable and proportionate to the threat to myself.

Incident involving detained person D1978 on 23 May 2017

56. I have reviewed my account of an incident involving D1978 on 23 May 2017 [CJS005646, p16-17]. This was a planned removal of D1978 who was being deported. The only clarification that I would make to my account is to the final paragraph when I state 'DCM Dix then asked D1978 if he was going to walk to CSU, he replied "no" DCM Dix then moved away from the door and asked us to enter the room. 'Although my report accords with my understanding of the situation at the time, it is clear to me having reviewed the footage of incident [Disk 48 20170523210142 e1606N 0013.mov] (which I have not seen previously) that D1978 indicated to DCM Dix that he would walk out of the cell. I believe there was a misunderstanding between DCM Dix and the officers – when wearing full PPE it is difficult to hear what is going on – and we misread his body language, believing as we entered the cell that the detainee was non-compliant. Once this misunderstanding had occurred, the detainee became verbally aggressive towards officers and healthcare staff, and I believe it was necessary to use force in those circumstances. I am asked to account for why I took control of D1978's head: when conducting planned removals of a non-compliant detainee we were trained to have two arms officers (who would take control of the arms) and a head officer (who would take control of the head). I released the detainee's head as soon as he indicated that would not resist, and we walked with him to CSU with his arms restrained. I do not recall witnessing DCM Dix step on D1978's foot. D1978 was verbally aggressive and abusive throughout the removal. Once we had made the initial error with regard to his non-compliance, I believe the level of force was necessary and proportionate in the circumstances.

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57. I am asked to comment on a discussion which took place between myself and some other officers regarding the input of healthcare [TRN000029, p22-23]. I do not recall this conversation. However, it appears from the transcript that I am expressing some frustration with a member of healthcare for leaving a detainee after offering him paracetamol, when I felt he needed further attention.

Incident involving detained person D149 on 31 May 2017

58. I am asked to comment on an incident in which I was called to assist in a planned use of force involving D149 on 31 May 2017. I was asked to assist as D149 was being verbally aggressive, and act as an anchor to prevent injury to the team as they descended the stairs. My role was to link onto the front officer and the banister to ensure no one fell down the stairs. I do not recall anything of note happening as the team descended the stairs. I do not recall D149 being hit during this incident. I was called as a support person and was not involved in the initial use of force, nor was I involved in the choice of action in the circumstances (which would always be made by a manager). I do not feel able to comment on the force used in these circumstances.

Incident involving detained person D390 on 5 June 2017

59. I am asked to comment on the accounts of DCM Povey-Meier, DCO Shadbolt and DCO Bromley of the use of force to facilitate the planned removal of D390 on 5 June 2017 [CJS005624]. I confirm that their accounts reflect my recollection of the incident. I do not recall my exact instructions to D390 when we entered his room but I would have given him a final opportunity to walk with us freely, without force being used. I would then have asked him to turn around so I could apply cuffs if needed. I cannot recall his exact response but the reports indicate that he refused to comply. I am asked to comment on the discrepancy between my account and that of DCO Bromley, in that I say I placed D390 onto the bed on the right side of the room [CJS005624,25-27], and DCO Bromley states that I placed him onto the bed of the left side of the room [CJS005624, p20-24]. I can only say

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that one of us must be mistaken, but am unable to provide further clarification so long after the incident.

60. I am asked why it was necessary to use force when D390 had indicated that he was happy to walk. My recollection is that at the point at which D390 said he was happy to walk, the officers reduced the force down to a guided hold, which would be a precaution given that D390 had initially resisted. I am asked to comment on a statement made by another detainee, who is recorded as saying: 'I can't believe you would do this to someone who's not high risk; I wonder what would you do to someone who is high risk.' The use of force would not have been determined by level of risk a detainee poses, but rather whether or not they complied with our requests to leave the cell voluntarily in order to be deported. I am also asked to explain why I felt it was necessary to use my shield. I used my shield, as I had been trained to do, when D390 was resisting; when he stopped resisting I stopped using my shield and the officers reduced the level of force to a guided hold. I consider that the force used in relation to this incident was necessary and proportionate.

Incident involving detained persons D2764 and D2902 on 5 June 2017

61. I am asked to describe the state of health and injuries sustained by D2902 after he was kicked by another detainee, D2764. Unfortunately I do not recall this incident and am not able to provide any further information in relation to it.

Incident involving detained person D313 on 15 June 2017

62. I have reviewed my account of an incident involving D313 on 15 June 2017, in which D313 approached me and tried to headbutt me whilst under the influence of the synthetic drug known as Spice [CJS005937]. This incident was investigated by G4S and resulted in my dismissal from Brook House after allegations were upheld that I used an inappropriate restraint technique and failed to provide a use of force report (see CJS005937, p9-12). I confirm that my account reflects my understanding and recollection of the situation at the time. I now know (as I have

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been shown CCTV footage) that there were two other officers in the vicinity at the time, DCOs Dan Lake and Gary Croucher. I was not aware that these officers were present as they were behind me and not in my field of view. The report states that I did not file a use of force report because I 'forgot about it' - I would like to clarify that the reason I did not provide a use of force report is because we were generally so understaffed that it would not have been possible to do it at the time, and by the end of the shift I had forgotten to do it (see CJS000813, p9).

- 63. My recollection of the incident is that D313 did not want to be in E wing because all of his belongings (such as his tobacco and his own food) were on his regular wing, and he was verbally aggressive and struggling with the officers who brought him to E wing. When he motioned to headbutt me, I grabbed his wrists and moved my head back far enough so that he could not make contact. I maintain that I did not strike D313 and I was not aware that the other officers had followed behind me, although I learned subsequently that they had when I was shown the CCTV footage.
- 64. I am asked to comment on whether the length of the shifts (13.5 hours) affected my ability to perform my duties. Although the shifts were long, the lack of staff on the wings was a far greater problem as it meant that the long shifts were much more intense than they should have been. If we had more staff support, we would have had more time for completing the relevant reports immediately following incidents rather than having to do them at the end of a log and busy shift. I am not aware of any other occasions in which I failed to report a use of force.
- 65. It is stated by the interviewer that I confirmed I had forgotten to call a nurse but did not realise this was part of the procedure [CJS005937, p4]. To clarify this, I was not aware that I was supposed to call a nurse where no injury had been sustained, or there was no apparent medical need. In practice, officers would only call healthcare where we considered there was a medical need to do so, or when a detainee requested it. This was my understanding of the correct procedure. I do

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not recall being informed during training that a nurse should routinely be called whenever there was a use of force.

- 66. I am asked to explain why I reported that I was alone during the incident with D313. As I state in para 62, I was not aware that other officers were present in the vicinity as they were behind me. I reacted to D313 coming towards me and motioning to headbutt me; there was not time for me to look around to see who was present and ask for help. My admission that I used personal protection skills rather than approved C&R techniques is recorded at page 9 of CJS000813. On this occasion, a detainee was trying to headbutt me and I responded in the moment in order to defend myself utilising the personal protection training I had received. I do not recall any other occasion when I used personal protection training rather than C&R techniques.
- 67. The BBC alleged that, following the incident, when I was asked if I had a 'good team,' I replied, 'no, that's why I did it on my own.' This comment was taken out of context. I believe I was referring to the fact that the other officers did not step in to assist me, so I was forced to react on my own. I did not even know they were present. Had the other officers assisted me when D313 approached me in the servery, I believe we would have acted together to escort D313 back to his room. I do not recall the alleged conversation but can only assume it was with DCO Tulley. DCO Tulley alleges in his witness statement that I said 'I picked him up, took him into the room and fell on him accidentally, using his face to get up' [SXP000120, p8]. Whilst we may have had a conversation about the incident I do not accept that I made this comment and in the manner alleged by DCO Tulley
- 68. I am asked to comment on my involvement on the investigation by Sussex Police.

 I was not aware that there was a police investigation into this incident and had no involvement. I was not contacted by Sussex Police at any time.

Complaint involving detained person D87 on 30 June 2017

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Witness Name: Sean Sayers

- 69. On 30 June 2017 I was involved in a use of force involving D87. By way of background, I did not wish to be involved in this use of force as I had a good rapport with D87 and I believed I could have persuaded him to leave his cell voluntarily. I asked DCM Brackenridge for permission to talk to D87 before force was used in order to try to de-escalate the situation; however, I was told it had been decided that a C&R would take place. I am not aware of who made that decision. I believe I should have been permitted to talk to D87 as I believe there was a very good chance I could have persuaded him to comply. D87 was a very big man, 6ft 5, and an ex kick boxer; 4 officers were injured on that day which I believe could have been prevented.
- 70. I have reviewed my account of the use of force [CJS005592] and do not wish to amend or clarify that account. I do not recall hearing DCM Brackenridge saying "get him" (as alleged by D87 in HOM002721, p9] (although I would not necessarily have been able to hear him due to the helmet, which makes it difficult to hear anything other than clear instructions). I confirm that I did subsequently apologise to D87 for the C&R and tell him that I was threatened with disciplinary action if I refused to be involved, which was true. Although I believe force could have been avoided if I had been permitted to speak to D87 prior to the C&R, once the decision had been taken to use force, I believe the level of force used was necessary and proportionate to the circumstances and risks posed to the officers by D87.
- 71. I sustained a shoulder injury during the incident. I do not recall being offered any support afterwards. It would have been good to have been offered some physio support or a medical check-up. I am asked what involvement I had with the C&R team after this incident. There was no specific C&R team; a team would be assembled to deal with each removal depending on who was on shift at the time. I continued to be required to be involved in C&R incidents and , as I explain at paragraph 44, it was not generally acceptable to refuse to be involved in a C&R if requested by managers.

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Witness Name: Sean Sayers

Drugs at Brook House

- 72. I do no recall the incident detailed in document CJS005178.
- 73. I came across elicit drugs almost every day at Brook House. I set out in paragraph 17 the measures used to try to prevent drugs from entering, but these were not successful. The staff did their best to react to the problem (for example by carrying out room searches) but there was no overall strategy in place to deal with the issue. I do not know what could have been done differently to prevent drugs from entering or to deal with the problem of illicit drugs.

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	Sean Sayers	
Signature	Signature	
Date	28 february 2022	