BROOK HOUSE INQUIRY

First Witness Statement of Graham Matchett

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 4 November 2021.

I, Graham Matchett (DOB DPA), will say as follows:

Introduction

1. I have been asked to provide this witness statement to the Inquiry in connection with a position I held previously as a G4S Detainee Custody Officer (**DCO**) from 14 November 2016 to 20 May 2020. I left G4S to join the Metropolitan Police Service (MPS) and remain a serving officer. I make this statement in a personal capacity to supplement the evidence I provided to the Inquiry in the form of a witness questionnaire on 23 September 2021.

Management

2. I am asked to identify to whom I refer to at Q4 of my questionnaire response when I comment that *"some members of the SMT appeared disinterested when approached by detainees and asked questions."* I was referring to Deputy Director Steve Skitt.

Training

3. As far as I recollect Control and Restraint (**C&R**) training was completed annually. The training was conducted as a group session comprising a mixture of theory and practical training. PowerPoint presentations were used to remind us of our use of force powers and legal justifications; the National Decision Model and the various handcuffing techniques. The practical training consisted of

demonstration and practice of personal protection techniques such as the use of 'final locks' and 'guiding holds', handcuffing and the use of shields. This would be followed by a series of role-play scenarios in which the instructors would take on the role of a non-compliant or aggressive detainee in a mock wing or cell (which would consist of large foam walls and/or door and a foam bed to imitate a room on a wing). We would then conduct a mock planned removal of the 'detainee' as part of a team of three or four using methods, tactics and techniques that we had been taught.

4. The theoretical aspects of the training were tested via a multiple choice questionnaire. Officers were also assessed on their competence and technique during the practical scenarios. It was possible to fail the training: if the instructor failed you, you would usually be set a new refresher date to complete the training again. If you continued to fail refresher C&R training then your job as a DCO was at risk. If it was deemed that the officer was a risk to themselves and/or others then there was the possibility the officer would be given the opportunity to be an Assistant Custody Officer (**ACO**), a role which did not involve contact with detainees.

5. I always felt the quality of training was of a high standard and felt the content taught by the instructors prepared me well for my next shift on duty. I do not recall the specific dates on which I attended refresher courses.

6. During my time at Brook House I did not receive training in Minimising and Managing Physical Restraint (MMPR) techniques. This training was only applicable to officers working with children being detained with their families, and so was reserved for DCOs working at Cedars Immigration Facility and Tinsley House Immigration Centre.

Use of Force

7. I was asked in my questionnaire response to provide an estimate of the number of use of force incidents I was involved in during my time at Brook House. While I

am unable to recall such specific detail, in an attempt to assist the Inquiry I provided a rough estimate of the number of total incidents, including planned removals, spontaneous uses of force and planned removals that resulted in no force being used. I am now asked to account for why my estimated number of use of force incidents is so high as compared to other DCOs. It is not possible for me to be precise over the number of incidents I was involved in due to length of time that has passed since my employment (and so I cannot be confident that my estimate is accurate as regards the actual number of incidents). I am afraid I just cannot recall such specific detail. Therefore, I cannot be sure that I was in fact involved in a high number of incidents as compared to other staff.

8. I do not recall when body-worn cameras were introduced at Brook House (and whether this was prior to or following the Panorama programme. Body-worn cameras were used to create an visual and audio record of: (i) incidences of aggression or force by detainees either towards members of staff or other detainees; and (ii) the actions of the attending officers. My understanding is that the introduction of body-worn cameras was intended to provide reassurance to detainees who had concerns about the behaviour and actions of staff (in particular as highlighted in the Panorama episode), and to protect officers from assaults, allegations and complaints. In my experience they were an excellent deterrent in preventing detainees assaulting officers or other detainees.

9. I do not recall whether or not a set number of warnings had to be given prior to using force. I recollect occasions whereby two or three warnings would be given to a detainee prior to force being used but cannot be sure whether this happened in every case. There would also be occasions where it was not possible to give a warning to a detainee that force would be used, for example, if a detainee was armed with a razor blade or weapon threatening to injure themselves or officers if they entered their room prior to their removal directions. In those circumstances, officers would form part of a C&R team which would then be subject to full briefing; would enter the room and safely secure and the detainee using Home

Office (**HO**) approved C&R techniques; and would complete appropriate use of report reports.

10. I am asked to comment on my involvement in the reviews of the incidents described in documents CJS005529; CJS000894; CJS005646; CJS005562; CJS005577 and CJS005613, and any lessons learned. As a DCO, I would have not have had any involvement in the review of these incidents; that process was conducted by the HO. I do not recall the details of the incidents described in CJS005529 and CJS005646. It is not clear what incident is referred to in document CJS000894 so I am unable to comment. I set out my recollections regarding my involvement in the other incidents as follows:

    a. **CJS005562:** I was one of four officers chosen to relocate the detainee to the care and separation unit (**CSU**) as a result of his recall to prison. Due to the detainee using razor blades to prevent previous attempts to relocate him, authorisation had been given to use handcuffs on the detainee to safely conduct the move. I was instructed to secure the detainee's right arm once we were inside his room. Fortunately the detainee was fully compliant, but due to the risk of him being in possession of razor blades, he was handcuffed to the rear by DCO Carr. I took hold of tD693's right arm by placing my right thumb over the crook of his elbow with my right palm and fingers cupped under his elbow. My left hand was then firmly gripped over his right wrist in a 'guiding hold'. Once D693 was in room CSU/04, a full search was conducted by DCM Dix. I do not remember having any involvement in this search.

    b. **CJS005577**: This document refers to a spontaneous use of force which took place whilst I was on duty on Eden Wing. I had witnessed D2830 enter his room promptly followed by DCO Lunn. I also entered the room. D2830 was sitting on the edge of his bed with a razor blade placed against his throat. DCO Lunn was attempting to take a razor blade out of his hand. I took control of D2830's right arm and immediately placed his right arm/wrist into a 'final

lock'. This involved isolating the detainee's arm, creating a 'fixed elbow' whereby you would press/rest the detainee's elbow against your lower torso area and then apply pressure to the back of the detainee's hand by taking hold of their thumb and index finger together. Once DCO Lunn and I had placed D2830 into 'final locks' and DCO O'Connor had supported his head should he fall over, we instructed D2830 to walk out of the room towards the CSU. D2830 was aggressive and was actively trying to resist our efforts to relocate him to the CSU. I do not remember exactly what happened once in the CSU but according to my report, D2830 was attempting to kick us and attempted to bite DCO Lunn on his arm. My report states that DCO Lunn and I assisted him to the floor (still in final locks) with DCO O'Connor still on head support. D2830 calmed down enough to be assisted to his feet again where we walked him into room CSU/04. As D2830 had calmed down significantly, I de-escalated my 'final lock' on D2830's right arm into a 'guiding hold'. I then released my hold along with DCO Lunn and exited the room.

c. **CJS005613:** This document refers to an incident in which I was responding to a request from D1182 for paracetamol for a headache via his intercom system. At the time D1182 had been placed on a Rule 40, which meant his right to associate with other detainees had been removed due to his behaviour. D1182 was therefore in the CSU where the door to his room was locked. I attended with DCO Fielding and opened the door. D1182 approached me with a cup of water and demanded that I give him the paracetamol. DCOs are not permitted to hand detainees paracetamol tablets but must place the dissoluble tablets in the water ourselves, in order to prevent detainees from hoarding paracetamol for the purpose of taking an overdose. I explained this to D1182 but he became verbally aggressive and advanced into the doorway and blocked the door from closing with his foot and upper body. I requested that D1182 remove his foot from the door and move away, on at least four or five occasions, but he refused. D1182 was not permitted to leave his room due to the Rule 40. He was becoming increasingly aggressive towards me so I gave him one more opportunity to move back by giving him clear instructions to

move back from the door so that I could close it. D1182 again refused. I then used an open palm defensive strike on his upper body pushing D1182 back in order to close the door but he instantly came back to the door blocking it before I could close it. I felt my actions were justified in order to prevent D1182 from assaulting me and/or exiting CSU/01 without authorisation. DCO Fielding requested the first response team attend via the control room, who arrived shortly after.

Use of Force incident involving D2159 on 5 April 2017

11. As stated in paragraph 10, I do not recall the incident referred to in document CJS005529 so I am unable to add any detail not already provided in the report.

Use of Force incident involving D2183 on 11 April 2017

12. I do not recall this incident and , therefore, I am not able to comment on the level of force used, any injuries sustained or any de-escalation techniques utilised. Whilst I cannot be sure how D2183 had a blade in his cell (as I do not recall the specific incident), many of the detainees that self-harmed used disposable razors that could be collected from the wing office. Only one disposable razor was given to a detainee by a DCO at any one time providing they returned their previous razor and were seen to place it in the yellow 'sharps bin' located in the wing office. Detainees would break the razor's plastic housing off exposing the bare blade enabling them to secrete the small blade somewhere in or on their body. Unless a full search was authorised and conducted on D2183 prior to entering his room in CSU, it would have been very difficult for an officer to find the razor blade hidden on him. There were occasions when detainees who were expecting to be served their removal directions by the HO would keep razor blades on their person in anticipation of officers attempting to hand them over to the awaiting escorts to take them to the airport. These were used either to threaten or carry out acts of self-harm.

13. I am asked why the log does not record any injuries to D2183's neck. It would be the responsibility of the supervisor or Oscar 1 (the manager designated as in

charge of the wings on that particular day) to ensure that all appropriate reports were made, including to healthcare.

Use of Force incident involving D1978 on 23 May 2017

14. As stated in paragraph 10, I do not recall the incident referred to in document CJS005646 so I am unable to add any detail not already provided in the report.

Use of Force incident involving D693 on 9 July 2017

15. Please refer to paragraph 10(a) for a summary of my involvement in this incident.

16. The techniques used in this incident were a guiding hold, which was necessary to place D693 in handcuffs. A search was also carried out. These measures were considered necessary and proportionate following a risk assessment by security officers as a result of the detainee's history of being in possession of razor blades in an attempt to avid being recalled to prison. On that day D693 was fully compliant and the handcuffs were applied promptly. I consider that the force used was reasonable and proportionate to the potential risk to staff and D693 himself. I cannot recall if any de-escalation techniques were used prior to the use of force.

Use of Force incident involving D2830 on 12 July 2017

17. Please refer to paragraph 10(b) for a summary of my involvement in this incident.

18. I would characterise the incident as an unplanned spontaneous use of force. D2830 had placed a razor blade to his own throat and officers had a duty of care to prevent D2830 from seriously injuring himself. We also needed to take prompt and decisive action against D2830 to prevent the possibility of him using the razor blade on another detainee or ourselves. The force used on D2830 was proportionate and necessary and was executed in a professional and safe manner due to us following HO approved techniques. Given the potential risk of harm, I believe our actions were reasonable. Once we had moved D2830 to CSU further force was deployed to assist him down onto the floor: this was necessary as D2830 became physically aggressive, attempting to bite DCO Lunn's arm and

kick the other officers present. I believe this action was reasonable and proportionate to prevent harm to the officers.

19. I was not present when DCO Lunn initially entered the detainee's room so I cannot say what de-escalation techniques were used prior to force. Force was already being used on D2830 by DCO Lunn when I entered the room in an attempt to remove the razor blade from his throat. D2830 was refusing to comply with verbal requests to drop the razor blade at this point.

Use of Force incident involving D1182 on 16 August 2017

20. Please refer to paragraph 10(c) for a summary of my involvement in this incident.

21. I am asked to describe the actions of DCO Fielding during this incident. DCO fielding was standing either directly behind me or slightly to the side of me throughout the incident (there was not sufficient space in the doorway for us to stand side-by-side). DCO Fielding called first response when D1182 refused to comply with my verbal instructions. At this point I had deployed an open palm defensive strike to force D1182 back away from the door but he had immediately moved forward again and prevented the door from closing. I cannot recall who arrived on the scene or what happened at that point onwards as I moved away to allow the attending officers and manager to take control of the situation.

22. I used an open palm defensive strike on D1182's upper body pushing him back in order to close the door: this was a spontaneous unplanned use of force with a minimal amount of force used. As soon as it was apparent that D1182 intended to stand his ground physically and prevent the door from closing DCO Fielding called for first response and no further force was deployed by myself or DCO Fielding. In hindsight it may have been a better option for one of us to call for the first response team the moment D1182 started to become non-compliant; however, I believe that the decision I made was reasonable in the circumstances. D1182 was standing very close to me in an aggressive manner and I believed there was a threat towards myself and DCO Fielding.

23. I attempted to de-escalate the situation prior to using force by explaining to D1182 the reasons why it was not permitted for me to hand him the paracetamol tablets, and that this applied to all detainees housed at Brook House. When he moved forward and blocked the door with his foot and upper body I asked him three or four more times to move away from the door. I only used force at the point at which I became concerned that D1182 was going to assault me or DCO Fielding.

Complaints and Investigations

24. I am referred to document CJS004835 which describes an incident on 5 June 2017 during which D720 tried to force his way onto B wing and made threats towards me. D720 attempted to gain access to B wing (Beck Wing), stating that he needed to use the fax machine. As B wing was the induction wing, detainees not housed there would be granted access to use this fax machine only if no other fax machine at the centre was functioning properly; the machine was reserved for use by new arrivals who would need to send documents to their solicitors after being detained. Detainees were not generally permitted to access other wings and so this would be the only circumstance in which access would be granted (and as such was often cited by detainees as a reason for requiring access to another wing). On that particular day I had previously spoken with DCO Edon, who was rostered on D wing (Dove Wing), and he had confirmed the fax machine on the wing was working without issue. I explained to D720 that I had been told by DCO Edon that the fax machine on his wing was working. D720 then forced his way past me using his body and made threatening remarks towards me (the nature of which is contained in document CJS004835). This incident was witnessed by DCO Tomsett and DCM London.

25. I have reviewed the use of force and incident report relating to an incident which took place on the following day, 6 June 2017 (CJS001526, pages 105-108, 112). I have also reviewed CCTV footage of this incident, which I had not been shown prior to my involvement in this Inquiry. Having reviewed the CCTV footage, I can see that it was not in fact me who opened the wing door to D720, as was stated in

my use of force report. It was in fact DCO Chris Brown. I moved forward when I saw D720 standing in the doorway trying to get access to the wing. This is the only detail of my use of force report which is not accurate, to the best of my recollection. I confirm that I was not shown any CCTV footage of this incident during the Professional Standards Unit (**PSU**) investigation.

26. The incident on 6 June 2017 concerned a spontaneous and unplanned use of force on D720. I would characterise the level of force used as minimal. I released D720's arm as soon as he had stopped advancing onto the wing. I believe that the force I used on D720 was proportionate, reasonable and necessary in the circumstances to protect the safety and security of detainees residing on A wing (Arun Wing).

27. The incident on 6 June 2017 (referred to in paragraphs 25 and 26 above) was the subject of an investigation due to a complaint made by D720. The account provided by D720, which prompted the PSU investigation, was false. He alleged that I twisted his arm and used excessive force but this was not the case. I would describe the PSU investigation as neutral, detailed and thorough. The PSU investigator reviewed CCTV footage of the incident; witness statements by myself and DCO Opoku; and the report of healthcare staff. The investigator also tried to speak to D720 but he declined to give his account of the incident. After reviewing the available evidence, the PSU investigator found D720's claims to be unsubstantiated. I have reviewed the minutes of my interview to the PSU investigator (CJS001526) and confirm they are an accurate summary of the conversation to the best of my recollection. I have also reviewed the minutes of the interview with DCO Opoku (CJS001526) and confirm that his account of the incident is accurate to the best of my recollection. I do not recall when I was informed of the outcome of the PSU investigation.

28. I am asked to consider document CJS004835 (page 5) which states that I was referred to the care team as a result of the two incidents involving D720. I believe

this was because he had forced his way past me and make threats towards me. I do not recall what support was provided by the care team.

29. Document HOM002536 records that no accreditation check was required as no force was used. This document was produced by the PSU and I am unable to provide any explanation in relation to it.

30. I am not aware of the processes in place governing the referral of detained persons' complaints to the police; I believe this would have been overseen by the security team. I confirm I was not contacted by Sussex Police, nor am I aware of anyone else being contacted by Sussex Police in relation to this incident.

31. The PSU investigation concerning the incident with D720 on 6 June 2017 was not included in my questionnaire response to Q13 as, due to the time that has passed since this incident, I did not recall it until prompted by the relevant reports. For the same reason I am afraid I cannot recall whether or not I had contact with D720 during the investigation of his complaint. There were no further issues between myself and D720 to the best of my recollection.

Individual Welfare

32. The Inquiry has asked for my views on the reasons for detainees' self-harming, and the extent to which this was motivated by a desire to delay or prevent their deportation. Whilst clearly it is not possible for me to be sure of the motivation for these actions, I would say that imminent deportation appeared to be the reason in some, but not all, cases.

33. If an individual expressed thoughts of self-harm, the officer who was given this information would be open an Assessment, Care in Detention and Teamworking book (**ACDT**). The ACDT would set out an action plan and would record details of the detainee's caseworker. A mandatory review by an ACDT assessor would be completed within 24 hours of the opening of the ACDT. Once this review had taken place, the assessor and the case manager responsible would determine how often observations needed to be conducted on the detainee. This would range from

just one or two observations by staff per day to half hourly observations, or a constant watch in the most concerning cases. If the detainee was considered particularly high risk (for example, where there had been threats of self-harm or suicide) they would be placed on a constant supervision. If the detainee was put on a constant supervision, the observations made by the officer would also be recorded in the ACDT. This would provide the information necessary to consider the risks and appropriate management of the detainee.

34. I have reviewed document CJ005608 which describes a use of force incident on 23 May 2017 concerning D812. I do not recall this incident and, therefore, cannot provide any further detail to what has been recorded in the report. I have no recollection of the review on 12 July 2017 in relation to D812.

35. I have reviewed document CJS000895 which contains a brief description of an incident involving D855. I have a vague recollection of a detainee using the melted rim of a plastic cup to self-harm. I believe this has stuck in my mind as it was not a usual occurrence. However, due to the amount of time that has passed since the events in question and the large number of incidents I dealt with over the course of my time working at Brook House, I am unable to recall any further details or circumstances which would assist the Inquiry (including the identity of the detainee).

36. I have reviewed documents CSJ003080 and HOM004054. I cannot recall the identities of the detainees or why I placed them on a raised concern. A raised concern would usually be noted where a detainee has some additional need, for example, a disability or injury.

37. A detainee with a long or serious offending history would not necessarily be deemed to be high risk for the purposes of their room share risk assessment (RSRA). I am afraid I do not recall the precise criteria to be met for a detainee to be deemed high risk. When a detainee was considered high risk, arrangements would be made to ensure they were single occupancy only. If there was insufficient space on the wings to accommodate this, they would be housed on E

wing. If a DCO considered that a detainee posed a risk of violence or bullying to others, they could recommend to their wing manager that the detainee be considered high risk (and this would be recorded on the computer system by the officer). The recommendation would be passed on to the security team who would make a final decision.

Behaviour of detained persons

38. I am asked to comment on an incident on 2 April 2017 in which I gave a verbal warning to D484 when he tried to force his way onto a wing. I do not recall the identity of D484 or this incident.

39. Document CJS001927 contains a report by another officer of violent and threatening behaviour by D484 on 6 April 2017, including pushing me back on my chin. Although I vaguely recall a detainee making contact with my chin, I do not recall the specific detail of the incident or whether any action was taken as a result of it. If a detainee was deemed a risk to the safety of officers (for example, as a result of threatening and aggressive behaviour) the officers would call first response via the control room. If there was no immediate risk to safety, threatening or aggressive behaviour could be reported to the officer's wing manager. I do not recall which process was followed in relation to this incident.

40. Document CJS005295 records an incident on 5 June 2017 in which D143 was threatening towards myself and DCO Tomsett, and made an accusation of racism towards DCO Tomsett. Whilst it is suggested (R9, Q64) that an allegation of racism was also made against me, this is not the case. I do not recall whether or not D143 was moved away from the induction wing, but in the *updated actions* section of DCO Tomsett's security information report (**SIR**), DCO Murphy has recorded:*'D143 moved to A Wing, Security Bulletin completed'*. The SIR has been ticked as 'closed' by DCO Murphy, confirming the move of D143.

41. I have reviewed document CJS005394 which records an incident involving D1436 being threatening towards DCO Ward. As I was not directly involved in the

incident, I would not have been informed of what action was taken as a result of it, either by DCO Yates or any other officer or manager.

42. I have reviewed document CJS005338 which records that I checked D1954's sink after he reported that it was flooding. My recollection of this incident is that D1954 had asked for DCO Milburn (a female officer) to go upstairs to his room to look at his sink as he said it was flooding. I told DCO Milburn I would go instead as I was already on my way from the first floor to the second. D1954 made it clear that he wanted DCO Milburn, and not me, to come to his room. However, I continued as there was no reason why any specific officer would need to check the sink. After entering the room, I ran both taps to check whether there was any issue with the sink but the water drained away without any problem. I told D1954 that the drainage was working fine and I then left the room. At no point did I push D1954 as he alleged in the wing office shortly thereafter.

43. As a result of this incident, I submitted an SIR advising that female officers should not enter D1954's room due to his attempts to get a female officer to come to his room alone. This was actioned by security and officers were later made aware of this during subsequent morning briefings in the meeting hall. As far as I was aware, female officers took notice of the warning issued by security and did not enter D194's room alone.

Drugs at Brook House

44. I have reviewed document CJS005246, which describes an incident on 1 April 2017 involving a report of suspicious activity in room A120. I am asked to comment on the reasons for the delay before the relevant rooms was searched. I note that while the question refers to the searching of cells, we did not refer to rooms as cells due to Brook House being a detention centre rather than a prison. Unfortunately I cannot recall how much time passed before clearance was given to search the rooms. Clearance would have been given by the Security team and I would not be privy to the reason for any delay.

45. In order to prevent drugs entering Brook House, visitors coming to the centre for pre-booked visits with detainees would be searched by ACOs once they had entered through the visitors entrance. This would sometimes result in drugs being found on the visitor's person and the police would be called to deal with that individual. The visitor would then be placed on a banning list prohibiting them from returning to the centre. There were also officers, usually one or two, that would be posted to the visits hall to oversee the visits. The officers would position the visitor approximately one metre away from the detainee once seated with a small table in between the two parties. This table was to ensure distance was maintained between the visitor and the detainee and that no drugs could be passed from the visitor to the detainee should the visitor have been successful in bringing drugs into the visits hall. I believe there were occasions where drugs were passed from the two parties when standing up and physically making contact with one another. If this was missed by the visits staff then there was a high chance the detainee would then be able to take the drugs onto the wings after their visit.

46. Post was X-rayed on arrival to the centre and any suspicious contents or smells emanating from the post were reported to management and security. The detainee would then be called down to reception where a reception DCO, a member of security and Oscar 2 would open it in front of the detainee explaining their suspicions. If drugs were found then the detainee would be questioned about the origin of the letter or package and the police would be informed by the security department.

47. As far as I recall, no training was provided to me regarding controlling the supply of drugs into Brook House.

48. I have no recollection of the incident described in document CJS005386. In relation to this (and other incidents that I cannot recall) it may be that if I were provided with the names and a reception photograph of the detainee in question, it may jog my memory. During my time at Brook House I encountered a large number of detainees and dealt with many incidents, which makes it challenging to

recall the specific details so many years later. I have reviewed all of the documentation provided and made every effort to assist the Inquiry as far as possible.

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	GRAHAM MATCHETT
Signature	**Signature**
Date	10/01/2022