

## **BROOK HOUSE INQUIRY**

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### **First Witness Statement of Owen Syred**

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

My address is known to the Inquiry, and I will say as follows:

#### **Background**

1. I worked for two periods with G4S as a Detention Custody Officer (“DCO”) and Welfare Officer. The first period started in October/November 2009. I then resigned in late 2012/early 2013 for a role with the company GEO (a secure prisoner service provider) as a prison escort officer in connection with Court and Tribunal appearances. However, I returned to G4S in approximately April 2014 where I remained until June 2021 when I was dismissed by Serco, the successor organisation to G4S at Brook House, on 16 June 2021 on grounds of ill health.
2. From late 2009/early 2010 I worked on C Wing. Then, in 2011 I worked on E-Wing for 8-9 months. E-Wing is where detainees who had been removed from association were accommodated. It was also referred to as Removal From Association (RFA). This is where much of the Panorama documentary was filmed. While I worked on the Wing, it was a very stark place, there was no pool table or other recreation activities, and detainees would be locked up all day and they were just let out for meals, exercise, and showers.
3. In 2010, I became an Assessment Care in Detention and Teamwork (ACDT) assessor. In this role I was part of a team that implemented safer custody processes. If someone self-harmed or threatened to do so an action plan would be put in place to keep them safe. ACDT assessments with detainees could take 10 minutes or they

could take 4 hours. These assessments were additional to my responsibilities as a DCO, and other members of staff sometimes made you feel like you were skiving by carrying them out, especially in the first few years. However, when I returned in 2014 the situation had started to improve, and it continued to get better.

4. While working on E-Wing, I also worked on charter flights as overtime. I was then approached by Nathan Ward, a senior manager at Brook House, who managed the pre-departure lounge at Tinsley House for family removals, to work as a Family Care Officer at Tinsley House.
5. Mr Ward had previously worked at the Medway Secure Training Centre (a secure centre managed by G4S for youths who had been convicted of criminal offences) together with Ben Saunders (the Director of Brook House). Medway Secure Training Centre was also the subject of a Panorama documentary, concerning the treatment of children at the centre, and I distinctly remember Ben Saunders warning the staff at Brook House (correctly as it transpired) that a similar documentary to the Medway Centre could happen at Brook House.
6. For my role as Family Care Officer at Tinsley House, I attended a six-week training course to learn about how to work with children and families (including paediatric first aid, safeguarding, and child protection). It was nice accommodation compared with Brook House and families with children could only be detained there for 72 hours maximum, prior to removal. There were not large numbers of families detained. I enjoyed this role and did it for about a year.
7. After leaving G4S around late 2012/early 2013 to join GEO, I found that I missed the interaction with people (the detainees) that I had experienced at Brook House, and I returned to G4S and Brook House in June 2014.
8. I became a Welfare Officer in mid-2016. Then from December 2016 I spent 5 months working with the Home Office on a pilot for voluntary removals, which proved to be very successful. I returned to my work as a Welfare Officer in 2017.

Witness Name: Owen Syred  
Statement No: 1  
Exhibits: OS1 and OS2

9. In November 2016 I became accredited as a safer custody trainer, through a National Offender Management five-day residential course (between 21-25 November). Following my accreditation, I was able to train colleagues in mental health and bullying issues, de-escalation techniques, and how to perform assessments of detainees at risk of self-harm. I also provided refresher training to G4S colleagues.
10. Also in 2017, I attended a 2-day course on immigration law delivered by Amnesty International, to gain an understanding of the legal issues involved in immigration, so that, as a DCO, I was better able to engage with detainees who were subject to the legal process of removal or deportation.
11. I was encouraged by my managers to apply for a role as a Detention Centre Manager (DCM). I passed the online test and was waiting for a vacancy to arise. However, in 2020, while at work, I aggravated an injury that I originally sustained in 2016, which left me unable to perform control and restraint work, and I was subsequently dismissed on grounds of ill health in June 2021. I suggested to Serco that I should be allowed to continue in my role as Welfare Officer without the necessity of control and restraint work (as there are other roles within Brook House that do not require this function), but Serco were not agreeable.

### **Application process**

12. Prior to 2009 I had not worked in a security environment before. However, I had an interest in working for the prison service, and I liked working with people. I saw two roles advertised at Brook House, for Assistant Custody Officer (ACO) and DCO. I applied for the role of ACO, which didn't involve control and restraint work. I had previously worked in a management capacity within the construction sector, and I saw this as an opportunity to develop and learn new skills, and to progress a long-term career.

13. I attended a selection day which included a presentation with information about the nature of the roles. The process involved psychometric tests, a medical, background checks, and an interview. Approximately 30 people attended the selection day. At the end of the selection day, I was offered the role of DCO.
14. The role as advertised was entirely unrepresentative of the reality of the situation. You weren't told about the level of hostility, the violence and self-harm, or about the difficulties with staff shortages and morale. Even the shift pattern was misrepresented. It was described as four days on and four days off. However, the pattern was much more irregular and included half days, which was difficult to plan your personal/home life around. Staff were also put under pressure while on probation to opt out of the working time directive of a maximum 48 hours in a working week. A lot of staff left very quickly after starting because the reality of the job was not as it had been described, and this put pressure on the organisation in terms of staffing levels as well as wasting resources by training people who weren't the right fit.

### **Culture**

15. When Brook House first opened in 2009 it was a dreadful place, 90% of the detainees were foreign national criminals and it was infested with drugs. There were also problems with prostitution, bullying, and gambling. Just before I started there was a riot on A-Wing and a specialist prison service team, the advanced control and restraint team, had to be called to deal with the issue. Fights would break out amongst detainees and with the DCOs. Faeces were thrown at officers. It was a very menacing atmosphere which you could cut with a knife. In 2010/2011, the Centre was inspected by the Inspectorate of Prisons, and I remember that the inspectors themselves didn't feel safe. Detainees regarded the DCOs as the enemy and the culture was us and them.
16. The ACDT process was not considered to be important by most staff in the first few years and I think this was because there was so much other stuff going on. However,

on my first set of night shifts I encountered a detainee who attempted suicide and I knew how important the risk assessments were and that they could save someone's life. I would be criticised by colleagues for spending time on assessments. Whereas, if you were involved in a control and restraint task, everyone would praise you. It was quite a macho culture, in which the care of detainees was secondary and for many years, I felt like a lone voice (things started to improve in 2016/17).

17. There was always a high turnover of staff and I believe the reasons for this were the failure to recruit people who were interested in a long-term career, the lack of recognition and reward for experience (an experienced DCO would be paid the same as a new recruit), and the stresses of the role. On my return to G4S in 2014, after roughly one year away, approximately 75% of the staff were new.
18. When I returned to Brook House in 2014, I was initially assigned to the Control and Security Team but I asked to go back on the Wings where I could engage and interact with the detainees. However, a lot of the new staff did not want to work on the Wings and did not appear to be taking the job seriously. On one occasion I had to escort a detainee to hospital with two colleagues and they never once spoke with the detainee. They just discussed their personal lives together in front of the detainee as if he was not present.
19. Staff morale was low and planned interventions were the only occasions when many colleagues showed any enthusiasm (planned interventions usually involved escorting a detainee to a removal flight, or removing them from association because of disruptive behaviour).
20. The hours were too long. On a typical day at Brook House, I would leave home at 06:45 to start work at 07:30. Lock up was 21:00 and if things went smoothly, I might get away by 21:30, and be home for 22:15. However, if there was a problem with the roll count on lock up or if there was a protest (sit-in) it wasn't uncommon to get home after midnight.

21. Senior Managers were not visible on the shop floor (although my manager, James Begg was very good) and staff didn't feel like they were supported.
22. In my first period at Brook House (2009-2013) it felt like the staff gelled better and we were more of a team, which I attribute to the very difficult circumstances we experienced collectively just after Brook House opened.
23. Several prison service staff were temporarily engaged when staff shortages were particularly acute. However, they didn't integrate particularly well.
24. Regarding the general protection of detainees, the detainees didn't feel safe on the Wings. They were afraid of intimidation, bullying, theft, and of being drawn into drugs by other detainees, and didn't always feel that they could approach staff for assistance. Although I only formally became a specialist Welfare Officer in 2016, I always felt that it was the role of every DCO to ensure the welfare of the detainees. However, many DCOs would make no attempt to assist detainees and would simply refer detainee queries to the Welfare Officers. Prior to the Panorama documentary there were only four Welfare Officers (two each shift and sometimes just one), which was insufficient for this important function. There are now 16 Welfare Officers.
25. The structure at Brook House was disjointed and the detention centre never had an opportunity to bed down. Many of the detainees had been housed in category B prisons and suddenly had a lot of freedom (relatively) within the detention centre. The detainees would refer to new inexperienced DCOs as "pussies". They went from a strict regime to no regime, and there was a complete lack of planning.
26. When I returned to Brook House in 2014, Jules Williams was the Residential Manager, and he was in charge of the Wings and activities (he was more senior than a DCM and I believe he was part of the Senior Management Team). I refer to him in connection with a specific incident at paragraph 100 below. He wasn't visible on the Wings, and when he did make an appearance, he would find fault with staff in

Witness Name: Owen Syred  
Statement No: 1  
Exhibits: OS1 and OS2

front of the detainees. He was a demoralising influence and left Brook House after the Panorama documentary. If you were part of his social and drinking circle you were ok. Graham Parnell (a DCM) was someone in this group and I mention several incidents concerning Mr Parnell below. It was very cliquey and some of the DCMs were far too close to the DCOs within their social circles, which led to a culture where inappropriate behaviour was not challenged. An example of this is Nathan Ring (a DCM who is shown on the Panorama documentary) who behaved inappropriately but no one picked him up on it.

27. However, there were also some excellent managers such as James Begg (DCM and Safeguarding Manager), Michelle Brown (Security Manager and Head of Safeguarding and part of the Senior Management Team), Steve Laughton (DCM), Conway Edwards (a DCM who was also Race and Diversity Manager), Caz Jones (DCM), and Dan Houghton (Senior Management Team).
28. I had no awareness of the values and priorities of the senior management team while I worked at Brook House.

#### **Physical layout of Brook House**

29. Brook House is an H shaped building, with 4 main wings, A, B, C and D. B-Wing was smaller than the other Wings and accommodated new arrivals before they were transferred to the main Wings.
30. When Brook House was built in 2008 it was never intended to hold people for long periods. The recreation facilities were basic, and detainees were bored and would often sleep for long periods in the day.
31. E-Wing was for detainee protection and for people suffering from serious mental illness, and/or at risk of self-harm, and it was situated below B-Wing. E-Wing was always full up. There were also a number of temporary confinement rooms (six in total) within E-Wing, for detainees who had behaved disruptively. Their purpose was to allow time for reflection and to calm down. Detainees could only be kept in

confinement for a period of 24-hours without review. However, if a detainee was assessed as posing a risk of violence/harm to others then they could be kept in confinement for longer periods.

32. E-Wing was also known as the Care and Separation Unit. There were rooms which allowed for constant observation if there was a risk of self-harm. A detainee could also be accommodated on E-Wing if they were at risk from other detainees. There were 13 rooms on E-Wing, and as mentioned there were an additional six temporary confinement rooms (for disruptive or violent behaviour).
33. From about 2018 it became common practice to transfer a detainee to E-Wing just before they were due to be removed on a flight or transferred to another centre, because it was easier to move them from that location without causing disruption on the main Wings.
34. Other than removal, the procedure for accommodating a detainee on E-Wing was that a Duty Manager (a DCM) and/or the Duty Director (part of the senior management team) would decide whether to transfer a detainee to E-Wing. The Home Office, Healthcare, and the Independent Monitoring Board were notified of transfers to E-Wing.
35. In the early days most people were transferred to E-Wing because of violent and disruptive behaviour, but later the primary purpose was for the protection of the detainee. In the early years the atmosphere on E-Wing was quite stark and it was sometimes referred to as, "the block" although I was always careful not to use that term. It was easier to manage difficult behaviour and vulnerable detainees on E-Wing where the staff to detainee ratio was higher. Typically, there would be three or four DCOs and a DCM. If someone required constant supervision an officer would have to sit outside their room which required additional resource.

36. In terms of improvements, the centre would benefit from more indoor social areas, such as a coffee shop, where detainees and staff could integrate. In general, any steps to reduce the feeling of a prison would be beneficial.

### **Policies and Procedures**

37. There were a number of different teams within Brook House, as follows: Security (responsible for room searches, escorts to hospital, patrols of the perimeter, supervision of the control room and cameras, and back-up support on the Wings (although in practice back-up support was rarely provided)); Reception/Discharge (responsible for booking people in and out, and property (money and phones)); Activities (responsible for library, i.t. room, gym, cinema, and sports events on the exercise yards); Visits (including social, Home Office, solicitor and charity visits).
38. When I first started at Brook House, I was part of the Residential Team, which is responsible for staffing the Wings. It was a requirement that there should be at least 2 DCOs on each Wing. C-Wing accommodated around 135 detainees over three levels. However, I once worked three consecutive days on C-Wing on my own due to staff shortages.
39. The detainees would sleep and take meals on their Wing. In the first few years all the Wings were open to each other, but this policy was changed around 2011 following which detainees were only allowed on the Wing in which they were accommodated. Rooms were opened at 08:00 for breakfast and detainees returned to their Wing for lunch and evening meals. Lock-up and roll count was at 21:00, but this was always a struggle because detainees were reluctant to be locked in their rooms overnight.
40. The ACDT process was improved by Tony Bond (the Safer Custody Manager) around 2013/14, and when I returned in 2014, I could see that it was much better than the previous process. There was more emphasis on the need to make and record proper observations and G4S seemed to have followed the lead of the prison service in this regard.

41. Around the same time (2014) G4S recruited an experienced prison service officer as G4S Security Manager, Neil Davies, and he introduced more efficient and better processes. I recall that on one occasion he asked a team to carry out a room search, and they came back only five minutes later, in response to which Mr Davies remarked that they obviously hadn't completed it very well. He experienced significant resistance from DCOs who wanted an easy life.
42. The policies and procedures were outlined on the initial training course. They were available on the intranet, and a hard copy was available within the building. Prior to the Panorama documentary I was not aware of any staff refresher training. After the documentary, yearly refreshers were introduced on issues such as security, race and diversity, safer custody, and control and restraint. Policy and procedure changes and updates were circulated in hard copy (every team had a policy and procedure folder) and communicated to the DCOs by the DCMs. Later a series of "toolbox talks" was developed, which usually involved a DCM delivering training on a particular subject, such as searching procedures, and health and safety issues etc. I delivered a number of these talks to colleagues.
43. The policies and procedures were necessary. However, when applying them you had to exercise flexibility while maintaining consistency, which was a tricky balance. An overly officious approach would cause discontent and disruption.
44. A policy was introduced at Brook House that stopped DCOs taking their meals on the Wings, which I believe was an unnecessary and unhelpful rule, because it hindered your ability to integrate with the detainees. However, in the main the policies and procedures did reflect the realities of working at Brook House.

### **General Training**

45. I attended the Initial Training Course (ITC) between 9 November to 18 December 2009. It took place in the training room at Brook House and lasted six weeks. There were originally 20 on the course but only 16 finished. It covered first aid and control

Witness Name: Owen Syred  
Statement No: 1  
Exhibits: OS1 and OS2

and restraint, which are both mandatory courses. Other courses were race and diversity, safeguarding, safer custody, religious awareness, fire training, health and safety, security, drug awareness, and interpersonal skills. The trainer was Brian Russell who was an experienced custody officer. He was very good, and I ended up working with him at the family suite at Tinsley House a few years later.

46. I was nervous when I first started because I was worried about how I would cope when faced with aggression. I mentioned this to Brian during the training and he told me to keep calm, stand my ground, let them talk, and de-escalate the situation. He also encouraged me by telling me to, "carry on the way you are". I applied this approach throughout my career at Brook House and it worked 99% of the time.
47. Brian was honest with us about the reality, and that the situation at Brook House needed to be brought under control. The four people who dropped out of the training did so because they realised what was in store. Throughout the training we were told that the existing staff were really looking forward to us starting work because they were strung out and beleaguered.
48. Our training group received permission from the Home Office to start work as DCOs before our security clearances had come through because Brook House was so short staffed. I started work on C-Wing as a DCO, immediately after my training in late December 2009, and for the first few weeks on the Wings we weren't issued with keys or radios, because we hadn't received key training and there weren't enough radios to go round.
49. On my first day, I witnessed a significant breach of security and confidentiality. There was an office on each Wing (the Wing Office) which contained toilet rolls, toothbrushes, and cleaning products. Also stored in the office were copies of the detainees' IS91 forms (the authority to detain) which in many cases contained details of sensitive information such as criminal convictions. Although a DCO always had to be present in the office, detainees had open access to the office and would come and go freely. On the occasion in question, when I entered the office,

Witness Name: Owen Syred  
Statement No: 1  
Exhibits: OS1 and OS2

I saw a detainee sat at a desk using the computer. I initially mistook the detainee for a G4S colleague because I hadn't expected a detainee to be allowed in the room or to be given unsupervised access to G4S i.t. There was a DCO colleague already in the room and no action had been taken to prevent the detainee from using the computer.

50. A couple of days later I was asked by the trainers about my experiences on the Wing and I told them about the lack of security and open access to confidential sensitive information. They just rolled their eyes, and no action was taken. After a year or so I recommended to a Deputy Director that there should be a counter and a barrier to stop free access to the room. It took a while but eventually chest high countertops were fitted to prevent open access to the offices.
51. I think the training should have included more on teambuilding and teamwork (this is something that is delivered at Tinsley House as part of the training for work on the family suite). I think this would have emphasised the different strengths of different members of the team and helped build a stronger team. I also think there could have been more training on an awareness and understanding of the detainee's circumstances, which would have helped to see them as people in difficult circumstances and mitigated against an us and them culture.
52. Other than control and restraint (every year) and first aid (every three years) there was no refresher training in the first four years I was at Brook House. In the second period, more frequent refresher training started to be rolled out around 2017, after the Panorama documentary.
53. I am not aware of any specific training for activities officers. When I covered the library, i.t room and gym, and sports, I received no specific training. I refused to monitor the i.t. room until somebody showed me how to do it. Again, I believe that more training in this area, such as a gym qualification, was introduced around the time of the Panorama documentary.

54. In addition, I attended an ACDT assessor course between 19 to 22 April 2010, and on my return to G4S in 2014 I went through the ITC again (this was the third time in total as I attended the same training with GEO). As already mentioned, in 2017 I became accredited as a safer custody trainer, through a National Offender Management five-day residential course, and I attended a 2-day course on immigration law delivered by Amnesty International.
55. I can recall one occasion in 2017 when I witnessed the delivery of ACDT training by a colleague, Santiago Rodriguez, to new recruits, which was incorrect, because it suggested that the assessment shouldn't take longer than half an hour and the report only needed to be brief, whereas I was instructed that the assessments should take as long as necessary and to record all relevant information.
56. There was much more emphasis on training (including the quality of the training) following the Panorama documentary.

#### **Personal Protection Training**

57. Personal protection training was included within the control and restraint training as part of the ITC (it was half a day of the weeklong control and restraint training), and as mentioned already, control and restraint training was refreshed every year. The training was helpful but probably not adequate because it didn't incorporate de-escalation techniques.

#### **Use of Force**

58. Use of force was part of the control and restraint training delivered at the ITC. As mentioned already this was refreshed every year. My comments on the training would be that we were made to feel like control and restraint was the most important aspect of the ITC and in my training group there were a couple of colleagues who were almost too enthusiastic about the control and restraint training. Once on the Wing, becoming involved in a control and restraint exercise was treated as a rite of passage.

**The role of a DCO and relationships with detained persons**

59. Some detainees would try and intimidate new staff, and you could not let them see any signs of fear. On my first day on C-Wing I witnessed drugs being passed between two detainees while on the staircase and I challenged it in accordance with my training. I was with a colleague, Stephen Pearson, and we attempted a search. The detainees resisted and one of them threw a chair at me which hit me on my back, and first response was called as a result. Around this time, it was common for first response to be called five or six times a day.
60. I worked on C Wing for six years in total. I sought to build a rapport with detainees naturally by being approachable. Having a sense of humour was important and I would try to lighten the mood.
61. I would take my lunch with the detainees, and I recall on one occasion a DCO colleague, Keith MacGoughan, asked me “why are you sitting with these animals?” This was my way of trying to build a better relationship, and I would also wait my turn in the food queue. Another colleague, Nathan Ring (a DCO at the time) described me as a “cuddly care bear”, and separately as a “traitor”. He also said that I was, “all for the detainees not for the staff”. On one occasion I was called on the radio, and I heard Mr Ring say, “he’s cuddling a detainee”. I took this up with him and told him those sorts of comments over the radio were unacceptable.
62. I believe that first and foremost the role of a DCO is that of a carer and that I was there to look after people’s physical and mental welfare while they were detained.
63. The detainees knew that some of the staff would not do anything to help them, for example if a detainee didn’t know what to do with their immigration documents, or if they needed help with fixing something in their room, so they would approach me, and the other officers who tried to help. However, the downside of this approach was that we would sometimes be overwhelmed with detainee queries.

64. In October 2016 I was working as a Welfare Officer, and Michelle Brown (Security Manager and Head of Safeguarding) told me that I would be seconded to the Home Office on a voluntary returns pilot scheme as a Reintegration Officer. The role involved having discussions with detainees to find out whether they had any interest in returning to their home countries voluntarily and if so, what were the barriers to doing so. Michelle knew that I had good relationships with detainees which is why she selected me. I commenced this role in December 2016 and the pilot was very successful. I was nominated for officer of the month by a Home Office colleague for my work in facilitating the return of a Jamaican national who was subject to deportation. There had been several failed attempts to remove this person during which time he had become disruptive. I had several discussions with him and explained the process, and I arranged and made him aware that support and accommodation would be provided for him on his return to Jamaica.
65. I was very committed to the role of Reintegration Officer and had considerable success in identifying people who wished to return to their home countries voluntarily. Once the process was properly explained approximately 50% of the detainees were happy to return to their home countries voluntarily. Unfortunately, this role couldn't continue because of funding issues between G4S and Home Office and after five months I returned to my role as a Welfare Officer.
66. One of the most effective ways to prevent self-harm was simply to listen to what a detainee had to say. I would try to build a relationship upon a detainee's induction and greet them by saying hello in the language of their nationality (eventually I was able to greet people in approximately 20 different languages). I would also give them information about the immigration process and how they could access support, including assistance from charities, their embassies, and legal assistance. However, to do this effectively you need experienced officers who know what they are talking about, and the recruitment policies and procedures and the high turnover of staff at Brook House mitigate against this.

67. There is something called “jail craft” which you need to build relationships with people in detention. If you can build an understanding and a relationship, often with humour, it helps to manage what would otherwise be a very difficult situation. Some DCOs never understood this and made little effort to build relationships.
68. I also employed a technique called “dynamic security” which emphasises the use of interpersonal skills to ensure the safety of detainees and officers and I would use this approach at Brook House.
69. Use was made of interpreters, and we had access to a language line, “Big Word”. On occasion, other detainees would act as an interpreter. But you had to be careful in doing so and I wouldn’t use a fellow detainee as an interpreter when carrying out an ACDT assessment because of the sensitive nature of the assessment. Some members of staff with language skills were also used as interpreters.
70. At one time an enhanced Wing was introduced by a Deputy Director, to encourage good behaviour. The criteria for the enhanced Wing were an absence of disruptive behaviour and cooperation with the Home Office removal/deportation process. Detainees on the enhanced Wing could get a job in the kitchen, as a cleaner or assisting with various jobs around the centre. They were also given access to more tv channels. However, this didn’t appear to make a significant difference and it was discontinued within a year. There were also competitions between Wings for keeping the Wings clean, and sporting, art, and poetry competitions with trophies and small financial incentive for the winners. The competitions were very successful. There was also something called “cultural kitchen” which enabled detainees to cook their own food and to share it on the Wings. After the Panorama documentary, detainee forums were introduced (every two weeks) to give the detainees a means of making representations. The Director and/or Deputy Director of Brook House would be in attendance together with a representative from the Home Office.

71. All DCOs received training about safer custody and how to open an ACDT case (a hard copy log). A DCM would be assigned as a case manager. DCOs were trained to make and record observations. For example, a DCM may specify that three observations a day were to be made, in which case the observations had to be performed and recorded according to the direction. The main reason for opening an ACDT case would be because of a risk of self-harm, which might be because the detainee had self-harmed or threatened to do so, or from a report by a third party such as a family member or fellow detainee raising concerns. In 2016 I became an ACDT trainer, and I would always advise people if in doubt about whether to open an ACDT case, to open it, because it could always be closed.
72. When an ACDT case was opened an ACDT assessment had to be performed within 24 hours. In order to carry out an assessment you had to be trained to do so (I did mine in April 2010). The assessment process involved an interview with the detainee to assess the potential risks, and a report was then generated within the ACDT log. Potential outcomes from the assessment would be encouragement to keep in contact with friends and family, and arranged contact with the chaplaincy, charities and legal representation. The assessor would also recommend the level of observations to be undertaken and in extreme cases this could include constant observations (which would need to take place on E-Wing). It would be for the DCM to review the recommendations and to decide whether they should be implemented.
73. In respect of the steps taken to prevent drugs entering Brook House, anyone attending the centre would be subject to a search, including legal teams, and charities. G4S staff were subject to random searches, and I was personally subject to a number of searches. Contractors attending the centre needed to have an inventory for their tools and equipment.
74. One of the main ways drugs entered the centre was through social/family visits. These visits needed to be prebooked and proof of identification was required. However, despite the searches, drugs still came into the centre, and I can recall

attending the visitor centre on occasions when there would be such a strong smell of drugs. In the early days there was little restriction on physical contact during visits. However, this became stricter in an effort to reduce the quantity of drugs being passed on these visits. I can recall a search during which a detainee took a package of drugs from his mouth and placed it up his backside. There was no authority to undertake an intimate search and that was the end of the matter. No action was taken other than the detainee was subject to closed visits for a period of time. If a detainee was suspected to be involved in bringing drugs into the centre then they could be subject to closed visits which took place in a separate room with a glass screen and no physical contact. The duration of closed visits could be between several weeks and months, and there was an appeal process.

75. Detainees were only allowed to have basic phones in the centre which had restricted access to social media, and smartphones would often be smuggled into the centre, and these would be used to facilitate drug dealing.
76. My estimate is that somewhere in the region of 50% of detainees were taking drugs. The detainees were bored out of their heads, and the drugs were a form of escapism and a coping mechanism.
77. Another way that drugs entered the centre was through packages. Documents would be soaked in a drug solution and posted to detainees. To stop this practice staff would take photocopies of the posted documents to be provided to the detainees rather than the originals. I recall one occasion when a Vietnamese national was selling pieces of paper containing a drug solution (a type of hallucinogenic drug) which caused four detainees to collapse.
78. The type of drugs that were prevalent in the centre changed over time. At first it was heroin, and cannabis, and then later it became spice. As a Welfare Officer I would warn new detainees on induction of the risks of being used as a guinea pig

(to test the strength of new drugs entering the centre), and I would ask them to speak to the officers if they witnessed anything.

79. On one occasion, in 2015, a Chinese national offered me £25,000 to bring a quantity of skunk into the centre. He said to me, “how would you like to earn some money?” He wanted me to attend his family restaurant in Brighton and collect a quantity of drugs. He claimed to have another officer on A-Wing who was bringing drugs into the centre for him. I reported this to the security office and filed a security information report. I am not aware if any action was taken against the detainee or any member of staff.
80. Usually, following the filing of a security information report, because of intelligence and/or suspicious behaviour by a detainee, a planned search would result. If drugs were found on a detainee and it was a small quantity, for example cannabis for personal use, no action would be taken other than a verbal warning. Larger quantities would be referred to the police. I heard some rumours that staff had been dismissed for bringing drugs into the centre, but this was never officially confirmed. I do not know the names of the staff rumoured to be involved.
81. Detainees would make seemingly innocent requests of staff to bring something in like batteries or food, and if an officer acquiesced then the situation could escalate. I was asked on several occasions but always refused.
82. I find it odd, given the prevalence of drugs within the centre, that in all my time at Brook House I was never required to undertake a random drug test. Similarly, I can only recall one occasion where we used sniffer dogs. In my opinion, not enough was done to stop the drugs coming in.
83. I deal with my role as a Welfare Officer below under the heading, “Individual Welfare”.

84. In terms of Time Served Foreign National Offenders (TSFNOs), I was part of the security team for a short period of three months when I returned Brook House in 2014 (I quickly asked for a transfer back to the Wing where I could have more connection to the detainees). TSFNOs would be admitted to the centre with information about their offending history. The Detainee Escorting and Population Management Unit (DEPMU) would contact the centre to inform us that a TSFNO was to be transferred, and information about their relevant history including offending history would be provided. The IS91 (authority to detain) would also contain details of their relevant offending history. There was also a process called Multi-agency Public Protection Arrangements (MAPPA) which would identify particular risks such as sex offences, violent behaviour, and use of weapons, which would need to be taken into account when arranging visits (to protect members of the public) and when allocating tasks in the centre (for example avoiding the kitchen where there was access to knives).
85. There was a room sharing policy, which guarded against risks of radicalisation or violence. However, most detainees had to share because of capacity issues, and overstayers could be accommodated with serious criminals. Detainees were not segregated and vulnerable detainees were not protected, for example a student who might have overstayed their visa could be accommodated with a detainee who had committed a serious offence. I always thought this was wrong and despite raising concerns in focus group meetings, this practice was not changed.
86. Later, from 2018, there were weekly meetings called Detainees of Interest, at which concerns, such as radicalisation, issues connected to drugs, bullying and intimidation could be flagged.

### **Relationships with staff**

87. I deal with the issue of racism below under the heading “Disciplinary and grievance processes”.

88. In relation to issues of homophobia and misogyny I can recall one occasion when I carried out an ACDT assessment with a Portuguese national, and at the conclusion the detainee gave me a hug. Afterwards, the G4S colleague I was with commented, “oh, he likes you”. This was not appropriate, but I did not consider it serious. I mention below (paragraphs 100 and 101) allegations of sexism and homophobia made by colleagues against members of the senior management team.
89. In relation to the issue of staff bringing drugs into the centre, I mention above at paragraph 79 the claim of a detainee that an officer was bringing drugs in for him.
90. In around 2015/16 I can recall observing a DCO, Anita Morgan, failing to challenge the presence of a detainee who was a suspected drug dealer on C-Wing (the detainee was resident on B-Wing and at this time the detainees were not allowed to enter Wings where they were not resident). I raised the issue with Ms Morgan and explained that this was the third time he had been found on C-Wing and that I intended to give him a written warning. In response Ms Morgan said, “don’t go throwing your weight around with him”, which I took to be a threat. She claimed that the detainee was present on C-Wing because he was doing a job for her but she refused to explain what that was. In these circumstances, together with my colleague, Shaun Nicholls, we submitted a security report and spoke to the night manager, Steve Laughton. We inspected the security camera recording and we could clearly see the suspected drug dealer passing objects to other detainees on the stairs (which objects we assumed to be drugs) and before leaving he spoke in Ms Morgan’s ear in what appeared to be an intimate manner. Ms Morgan was subsequently suspended but I don’t know the precise details of the disciplinary proceedings.
91. I deal with the bullying to which I was subject below, under the heading, “Disciplinary and grievance processes”, in connection with an incident of racism that I witnessed.

92. I witnessed the bullying of another member of staff, Vimal (I can't recall his last name), by Graham Parnell (DCM). It was during roll count time and Vimal was either late in submitting the count of detainees from activities or they were not accurate, and he became flustered. Mr Parnell laid into him and accused him of not doing his job properly in front of several colleagues. I told Mr Parnell to, "lay off". The reason this incident sticks in my mind is because Vimal was a sensitive individual and because Graham's criticism continued for so long in front of others.
93. I can also remember the bullying to which another colleague, Dave Nicholson, a former police officer, was subject. I was asked by Jules Williams to spend a day with this officer and to provide Mr Williams with my opinion of him because there had been reports from some of the younger officers that he was a bit odd and that he was talking to himself. After spending the day with him, my opinion was that he was quiet but professional, and very good at his job, and I reported this view to Mr Williams. The younger officers called him "dangerous Dave" behind his back, and avoided working with, and behaved in an unprofessional and juvenile manner towards him. If you didn't fit into what others believed the role of DCO should be, they would ostracise you. I believe I was a victim of this attitude to an extent (see below under "Disciplinary and grievance processes"). Their attitude was, "you're not one of us".
94. The same group of DCOs also raised grievances against the Security Manager, Neil Davies, because he tried to introduce more robust processes, which involved more work (such as carrying out room searches properly – see paragraph 41 above). As a result of the resistance Mr Davies encountered from officers who weren't doing their jobs properly, he left his job. I can recall one of the DCOs commenting, "we'll get rid of him, he won't last".
95. There was also a female DCO, Gayatri Mehraa, who was rude and abrasive to both colleagues and detainees. She worked in visits and was moved to work on a Wing

because of the number of complaints made against her. She left Brook House shortly after she was transferred to the Wing.

96. In my view, senior managers did not sufficiently challenge inappropriate behaviour of this nature.

#### **Relationships with the Home Office**

97. I had a unique insight into Home Office colleagues because of my secondment. I got on well with Home Office staff and they always behaved professionally. The relationship between Home Office staff and detainees improved while I was at Brook House. At first, Home Office staff didn't like to attend the Wings because they felt intimidated. Home Office staff would meet detainees to inform them that their claim to remain in the UK had been refused, and this would often result in the detainee kicking off. However, as part of the returns pilot I was able to act in a liaison capacity and to explain the Home Office processes and their decisions to detainees on the Wing on behalf of the Home Office and this took a lot of pressure off Home Office colleagues. Debbie Smith, the Home Office manager with responsibility for Brook House, commented that there was a need for this role in every detention centre. Through better collaboration between the Home Office, G4S staff, and the detainees, for example at the weekly focus groups which all three groups attended, Home Office staff started to feel more at ease in the centre and this improved relations between the Home Office and detainees.

98. The Home Office had a difficult job to do but they behaved with compassion. I can recall an Eritrean national, who had fled Eritrea because of the civil war in which his family had been killed, who had also been subject to abuse while in transit to the UK. I assisted this detainee to complete the form to claim asylum and personally delivered it to the Home Office. The claim for asylum was granted and the Home Office officer who administered the claim, commented that it was cases like this that made the job worthwhile

#### **Relationship with senior managers**

23

Witness Name: Owen Syred  
Statement No: 1  
Exhibits: OS1 and OS2

99. James Begg (DCM) was my line manager. He was good at his job and very dedicated. In 2015 James gave me a positive end of year report. However, the end of year report needed to be countersigned by the Residential Manager, Jules Williams, who was part of the senior management team. Mr Williams commented that I sometimes went wandering and my colleagues didn't know where I was. I complained about this because I was doing my job of engaging with detainees on the Wing.

100. As I have mentioned (paragraph 26 above), Mr Williams was a demoralising influence and part of a clique. He was in charge of residential and activities and did neither job well. He once wrongly accused me and two colleagues of not completing paperwork properly, in an aggressive manner, in front of detainees and other staff, which was very unprofessional. I explained to him that we were not responsible as we had not been in work on the day in question, but he wouldn't listen and continued to direct criticism at me, as I had spoken up. I complained to the Director, Ben Saunders, about this and Mr Williams subsequently attempted to apologise. I intended to raise a grievance against him but was put off because I was told by a mutual friend and colleague that Mr Williams had received two previous warnings, one of which was in relation to a sexist comment, and that he may lose his job if I complained.

101. One of the Deputy Directors, Steve Skitt, who had previously worked in the prison service, had a condescending attitude towards colleagues, and he would make sarcastic comments. In 2018 I suffered an injury outside of work which damaged my hearing, and I was off work for a number of months. As a result, I initially returned to work in an administrative role and was not treated sympathetically. Mr Skitt said to me "when are you going to get back to your job?". This comment was made in the presence of an HR officer who asked me whether I wanted to complain about Mr Skitt's comment, but I declined. However, my confidence was significantly affected as a result. I understand that Mr Skitt was suspended at one

point in connection with an alleged homophobic remark made to a female officer in the gym.

102. Mr Skitt was wedded to the prison service way of doing things, which was not always appropriate within a detention centre setting where there is a need to be more flexible. Ian Danskin (Deputy Director) who was also ex-prison service, was similarly wedded to prison service procedures. This had a negative impact on life within the centre, for example they disparaged attempts to build positive relationships with detainees. Neither Deputy Director was approachable.
103. I had no issues with the Director, Ben Saunders. He was easy to talk to. He would be present on the Wings and around the centre. He was supportive of my secondment to the Home Office.
104. Some of the senior management team were good at their jobs, particularly those who had worked as DCOs, such as Michelle Brown (Security Manager and Head of Safeguarding) and Duncan Partridge (Deputy Director). Sarah Newland (Deputy Director) was also good and supportive (she put me forward for hostage negotiation training). There were approximately 4 Deputy Directors in post at any given time.

#### **Relationships with DCMs**

105. For most of my time my manager was James Begg, and as already mentioned, he was very good and supportive. There were three DCMs who stood out as being unprofessional, Ben Shadbolt, Kirsty Kane, and Graham Parnell. On one occasion when I was delivering training Ben Shadbolt and Kirsty Kane were sat in the training chatting and being disruptive, rather than setting an example to more junior members of staff, and I had to ask them to show some respect and courtesy. I mention a number of incidents involving Mr Parnell within this statement.

#### **Relationship with other DCOs**

106. There were two types of DCO, those who treated the role as a career and wanted to do their best, and those who did the bare minimum. I tried to engage with detainees

Witness Name: Owen Syred  
Statement No: 1  
Exhibits: OS1 and OS2

and would talk to them in their rooms, in a safe and respectful manner. However, I was criticised by colleagues for doing so.

107. Some of the staff who had been there from the beginning were very good. They had survived the first few years when it was most difficult, and they had developed resilience and experience. There was a camaraderie between staff who had been in the job for a while, which I enjoyed. However, on my return to Brook House in 2014 I noticed that the staff were very disjointed and there was an us and them attitude within the DCO/DCM team. The majority of the DCOs weren't in it for a career and it was just a stop gap for something else.

108. On one occasion, in 2016/17, I was on a Wing with a colleague, Chris Mallett, and we were carrying out a lock-up in the afternoon at approximately 16:30. We had over 100 detainees to lock up and roll count. I asked the control room for assistance, but I was told that there was no one available. We carried out the roll count with just the two of us and when I attended the Oscar 1's Office to hand in the head count form I noticed that six members of staff were in the gym (the DCM responsible for managing the centre on a particular day was known as the Oscar 1, and their office is right next to the gym). I complained to the Oscar 1 about the fact that I had requested assistance and was told that none was available when six colleagues were in the gym. No action was taken, and it was just brushed under the carpet. So I went straight to the Director, Ben Saunders, who issued a notice that staff were not to attend the gym until roll count was completed.

109. There was some backlash against me over this. However, I felt frustrated on behalf of those of my colleagues who worked hard, and there were too many staff who would do anything to avoid work. They would be in the control room on a computer unconnected to work, or they would conduct a room search and take an age to complete the paperwork. I can recall one occasion while performing room searches with a colleague, when I carried out 16 room searches in an afternoon and my colleague had completed just three. Many DCOs had no interest in the job unless

there was a control and restraint task, which was something they were excited by. There was a culture of laddish behaviour among large numbers of DCOs (I made this comment to Kate Lampard and Ed Marsden when interviewed for the Verita investigation following the Panorama documentary, and I note that there are numerous references to “laddish” behaviour within their report).

110. Around 2015 I complained to the senior manager, Michelle Brown (Security Manager and Head of Safeguarding), about a particular DCO, Carl Hallam, from D-Wing who would often ask me to carry out his detainee checks while on night shift (these are required observations through the night at regular intervals) as he would either be in the gym or taking a break. I originally complained to a DCM, Andy Lydon who was the Oscar 1 that night, but again my concerns were not taken seriously, and no action was taken. I was concerned about safety issues, because it was not safe to have one DCO looking after approximately 300 detainees across two Wings on their own (for day shifts there needed to be a minimum of two DCOs in each wing but after 21:15 this reduced to a requirement of only one DCO on each Wing). Ms Brown spoke to Mr Lydon about my concerns and the next day he asked me why I had created an issue, to which I responded, “I reported it to you, but you didn’t want to do anything about it”.

111. One evening, in the summer of 2017, on my way home from work I walked past a pub and recognised someone from my school, and we started chatting. I was in uniform, and he asked where I worked. When I told him that I worked at Brook House they said that he knew Graham Parnell (DCM) who also worked at Brook House, who had boasted that if any of the detainees got out of hand they were taken out of sight of the cameras and given a good kicking. My heart sunk at this and at the thought that members of the public had this view of the place where I worked. I just said in response, “some people might be like that but it’s not everyone”. I felt that all the good work some of us were doing was being undermined.

112. Just before I returned to Brook House in 2014, I was in the pub with my partner at that time and my brother. Graham Parnell was also in the pub, and he told me, “when you come back you’re going to love it because they have put more beds in the rooms and there will loads more fights”. My partner and brother were both shocked at this comment.

113. I was always open to shake the hand of a detainee and to pat a detainee on the shoulder as a sign of friendliness, but other DCOs and DCMs would disapprove of this practice and said that it didn’t look good. However, one thing I learned was that despite cultural differences, friendliness and a sense of humour would break through barriers and make the atmosphere calmer.

114. I tried to engage with detainees and would talk to them in their rooms. However, I was criticised by colleagues for doing so. I felt quite marginalised at times, and I mainly socialised with a minority of colleagues who had the same outlook as me.

115. Some colleagues would stereotype detainees, for example they would regard all people from Somalia as pirates. From 2017 I was part of the Race and Diversity Team, supporting Conway Edwards (Race and Diversity Manager and DCM) and I would deliver initial training courses to new recruits and staff refresher courses (which at one time were so frequent I would be delivering a session every week). I would caution against stereotyping and try and provide some understanding and insight to the background and experiences of many of the detainees. I would also talk about hidden disabilities and dietary requirements based on faith etc.

### **Relationship with Healthcare Staff**

116. Most of the healthcare team were very committed and professional. However, some, especially in the early days, were a bit dismissive and hard line with the detainees. On one occasion an Indian detainee required medical attention and was sitting outside the medical room on the floor. He had had a heart attack and I was

informed by a colleague that the healthcare manager stepped over him. He was later taken to hospital.

117. It was not uncommon for detainees to falsely claim that they were unwell in order to obtain their release from detention, and I think some of the healthcare staff must have become desensitised as a result. At one point a DCO had to be assigned to healthcare because the healthcare staff didn't feel safe from the detainees.

118. Communication from the healthcare team could have been better, particularly in the early days. But this did improve, and they would take my concerns seriously if I raised them about a particular detainee.

119. I can recall, in approximately 2015, an ex-Iraqi soldier who appeared to be suffering from PTSD. He was diagnosed as a danger to others by a psychiatrist. He spent time on E-Wing and was prescribed anti-psychotic medication. Once his condition improved, he was brought back onto C-Wing. However, after about a month I noticed that his condition had deteriorated again. I carried out some checks with the healthcare team and found that he hadn't taken his medication in two weeks. I queried why this information had not been shared with me and other colleagues, as the detainee had been diagnosed as a danger to others, and the detainee was subject to an ongoing ACDT log where this information could have been recorded. I raised this issue with Ben Saunders (Director of Brook House), because of the lack of a joined-up approach between the healthcare team and the DCOs.

120. The mental health team were brilliant, and very approachable, and as a Welfare Officer I was able to attend their office and discuss concerns about specific detainees.

121. I would provide new healthcare team members with an induction to the ACDT process.

122.The healthcare team had to be present on any planned interventions and if a spontaneous restraint was required then they would attend as soon as possible. In or around 2015, as a result of a death in custody on a return flight to Cameroon, the healthcare team assumed more of a lead role in any use of force and would instruct the G4S officers to remove the restraint if for example a detainee showed signs of struggling to breath. In the use of force procedures that I have been involved with, the healthcare team was effective.

123.The healthcare team was under considerable pressure when the use of spice was prevalent, and they would be running from one incident to the next in order to treat and revive detainees. There was a real concern that someone would die and the fact that someone didn't was testament to the effectiveness of the healthcare team and the DCO/DCMs over this period.

124.In my opinion the treatment provided by the healthcare team was at the same level as that found elsewhere in the NHS.

#### **Disciplinary and grievance processes**

125.On one occasion I witnessed a colleague making a racist comment and I was interviewed as part of a disciplinary investigation into this incident by Conway Edwards (Race and Diversity Manager and DCM). I exhibit the transcript of that interview to this statement, as exhibit OS1. The incident concerned my DCO colleague, Sam Gurney. I had completed my initial training with Sam, and he seemed like a nice guy. However, when I returned in 2014 there had been a big change in him, and he openly stated that he was racist. Some of the detainees were being quite demanding and he commented, "I bloody hate this lot, no wonder I'm racist". This took me by surprise because when I had known him before he was a sensible person. I said to him, "that's not you" and he responded, "it makes you feel like that", and I just left it there. A couple of weeks later, he was in the Wing Office on C-Wing, using the computer, and another DCO colleague, Liam Sharkey, was eating a packet of plantain crisps. I asked Liam what they were, and Sam interjected

and said, “they are crisps for niggers”. I couldn’t believe what he had said. I knew that I had to challenge the comment, but I didn’t want to do it in front of the detainees because this could have caused disruption. A detainee was stood nearby and I wasn’t sure if he had heard everything that had been said. The detainee said to me, “did I hear what I thought I heard?”. I told the detainee that I would deal with it and the detainee said, “I trust you to deal with it”.

126.I reported the incident to Conway Edwards and the exhibited transcript of my interview, OS1, records the details of the complaint. As a result, Sam was taken off detainee contact and put on duties in the control room. Through the investigation process I found out that Liam had not confirmed what Sam had said, which I assume was because of a concern about what others would think about reporting another colleague.

127.Following my report of this incident I started to receive post-it notes stuck on my locker that said, “nigger lover” and “grass”, and for about a year afterwards, friends of Sam in the control room would follow me around by camera and raise bogus reports to try and get me into trouble, for example a complaint that I had shaved in the barbers while on duty (which was false). I was also told by a colleague to watch my back and that people had it in for me because I had reported Sam. I reported this behaviour to the Director, Ben Saunders, and recommended that future recruitment should focus on more mature candidates.

128.I had to take time off work with stress because of the bullying and harassment I suffered from my own colleagues.

129.The culture within the organisation was that they did not want to make waves and did not want to generate publicity. Offences committed by prison officers are treated seriously, e.g. if a prison officer were to take drugs into a prison they would be prosecuted. However, I suspect that because G4S was a private company they did

not want to attract adverse publicity, and would try and deal with incidents quietly, in house, by bringing the DCOs contract to an end.

130. The only officer who I ever received a briefing about in connection with misconduct was from Ben Saunders, the Director of Brook House, in respect of Callum Tulley's covert recording of events at Brook House. We were informed that Mr Tulley had not gone through the right channels (he could have whistle blown) and he had brought recording equipment into the centre in breach of the rules. Mr Saunders also speculated that Mr Tulley's actions were for his own financial gain and career progression.

### **Staffing levels**

131. Brook House was opened in June 2009 by the then Home Secretary, Jacqui Smith, and was very quickly filled with approximately 400 detainees, the majority of whom were foreign national offenders who had been transferred from prisons. Most staff hadn't worked in a custodial setting before and the centre wasn't given chance to find its feet.

132. There were times when we were so short staffed that there weren't enough officers to work on the Wings, and the library and i.t. room couldn't be opened.

133. From around 2016, Welfare Officers would sometimes be deployed in other roles when there were staff shortages (e.g. the Wings, library, i.t. room, and escorts) which is an indication of the lack of priority attached to the role of Welfare Officer at the time. We all accepted that if there was an emergency then we would respond, but this was not that situation, and in my opinion, it was wrong to prioritise other work above the role of a Welfare Officer. After the Panorama documentary and the Inspectorate of Prisons report, Welfare Officers came to be seen as an integral tool for managing Brook House and there are now 16 Welfare Officers, whereas prior to Panorama there were only four of us.

134. Staff shortages were caused by a failure to provide career advancement for DCOs and to recruit people who were committed to the role and wanted to work at Brook House for the right reasons.

135. Violent and disruptive behaviour was more prevalent at weekends when the detainees had more time on their hands because they weren't engaged on their immigration cases. Staff shortages also contributed to disruptive behaviour in the centre and negatively impacted on the welfare of detainees, including the mental health of detainees, because of the lack of staff available to listen.

136. Staff felt overwhelmed. You couldn't do your job properly, and you couldn't give individual attention to detainees. You felt undervalued, and that management were not listening. You would finish a shift absolutely worn out and grateful that you were still alive, especially in the early days.

137. It went in cycles - there would be a recruitment drive and new staff would arrive, but quite quickly large numbers of staff would leave. There was never a period when there was prolonged stability. It has always been a problem.

138. I don't have any insight into staffing levels in the healthcare team.

139. Prior to 2017, activities were seen as ancillary to the main functions of the centre, in a similar way to the perception of the role of Welfare Officer at the time. Consequently, if there was a shortage in another part of the centre, staff from the activities team would be redeployed and the activities available to the detainees would suffer. Again, it was only after the Panorama documentary that activities assumed greater importance, for detainee welfare reasons, and additional resource was provided in this area.

### **Tinsley House Staff**

140. I worked at the family suite at Tinsley House in 2012. When Tinsley House was refurbished between the end of 2016 to Spring 2017, detainees were transferred to

Witness Name: Owen Syred  
Statement No: 1  
Exhibits: OS1 and OS2

D-Wing at Brook House. Tinsley House was a very different environment to Brook House, and it was much more relaxed with less of a prison feel (there were no TSFNOs at Tinsley House). As a result, many Tinsley House staff hated to work at Brook House. Whereas I found working at Tinsley House quite boring.

141. Detainees at Tinsley House received significantly more attention than at Brook House, where there was a much lower staff to detainee ratio.

142. Some of the Tinsley House staff were able to adapt their approach. Others couldn't. I remember one female colleague who hung around with me for protection and I took her to work with me in the welfare office. Other Tinsley House staff tried to emulate the macho/laddish approach of some of the staff at Brook House. For example, I can recall a kind individual from Tinsley House, Clayton Fraser, who in my experience was always willing to talk with and help detainees, and he is shown on the Panorama programme behaving out of character.

143. Tinsley House staff who were deployed at Brook House received additional training on the layout of Brook House, and they also received key training. No other additional training was provided. It was not uncommon for a Tinsley House staff member to be asked to cover a night shift on a Brook House Wing (when they would be on their own), and they wouldn't have a clue about what they were doing.

#### **Detained persons generally**

144. I assisted colleagues who worked on reception, by searching new arrivals, and escorting them to the Wings. In general, I found the staff on reception at both Brook House and Tinsley House to be professional.

145. The approach to admissions at detention centres differs from that at prisons. Prisons do not allow admissions after a certain time e.g., 20:00. However, detention centres accept detainees 24 hours a day. Consequently, detainees can sometimes be processed in the early hours of the morning when they are very tired and sleep

deprived, and they are asked questions about how they feel, and whether they are experiencing any thoughts of self-harm. In my view sensitive questioning of this nature should not take place at this hour and I have always thought that it was wrong not to have a cut off time for accepting new arrivals.

146.If a detainee had not been in detention before they would be scared, and the process could often take 3-4 hours (sometimes longer) depending on how many admissions were being processed at that time, which is far too long.

147.In the best-case scenario, the process would take a couple of hours to carry out the following processes: paperwork, property, search, fingerprints, provision of a phone, interview, and healthcare assessment. Then once on the Wing (which would be B-Wing for new arrivals) there would be a separate induction, and this could take another hour. Further delays might occur because new arrivals could not be transferred to the Wings while roll counts were being performed (there were 4 roll counts in a day, and sometimes more if a standing roll count was required).

148.The admission process is the first impression that a detainee has of the centre and significantly impacts their perception of the centre. In my view it is important that this process is performed well and there are improvements that can be made, particularly around the length of time the process takes, keeping the detainees informed of the likely duration of the process, and the introduction of a cut off time for admissions.

149.When I provided an induction to new arrivals, I always followed the policy.

### **Activities for individuals**

150.I have already mentioned the impact of staff shortages on activities and the knock-on adverse impact this had on detainees. People needed to be occupied and stimulated during the day otherwise they became depressed, especially at night. However, the solution isn't simply to make more activities available, the detainees

needed to be encouraged to participate, otherwise many wouldn't even get out of their beds during the day. For example, a cinema room was provided after the Panorama documentary, but it was still necessary to encourage people to attend a film screening. The benefits of activities were both that they helped with the mental health and wellbeing of the detainees and separately, if the detainees were engaged in activities this assisted with the security of the building and improved the safety of the detainees by reducing disruptive behaviour.

151. Even though the situation improved, there weren't enough activities, and Brook House was never designed for this purpose - it wasn't designed as the long-term holding facility that it became.

152. Activities that the detainees seemed to enjoy were cultural kitchen, the i.t. room (where they had limited access to the internet), the library (where they could play games such as chess), the gym, football and cricket in the yards, and table tennis and pool on the Wings. Teaching classes were also held, in subjects such as English language, art, and history. I would sometimes assist in these classes. The Wing yards were mostly tarmacked, but D-Wing was made into a garden and the detainees would like to congregate in this area, particularly in the evenings.

153. Boredom was the big problem, but after the Panorama documentary and towards the end of my time at Brook House there was more and more emphasis on activities.

### **Immigration Rule 35 Process**

154. My understanding of the Rule 35 process is that it imposes an obligation on the healthcare team to produce a report if the health of a detainee would be adversely affected by continued detention. For example, if someone claimed that they had been subject to torture, a medical examination would be carried out and a report to the Home Office would be produced by the healthcare team, which would include information such as whether there was evidence of injuries that were consistent with

their account, for example scarring. I never received any training about how to deal with this situation.

155. My practice in this situation was to listen to the detainees account, offer to provide contact details and to assist with arranging legal representation, access to Medical Justice, and to other charitable organisations, and to offer to arrange an appointment with the healthcare team for a formal Rule 35 report to be produced. I would also make a note of the information provided by the detainee on a database called DAT that we used to record detainee information and on the welfare spreadsheet (to be reviewed by the Safer Custody Manager).

156. In the early days the process was slow, and it could take months. Again, it was only after the Panorama documentary that this process significantly improved and might now only take one to two days.

### **Use of Force**

157. Some of the DCOs had no interest in making Brook House a better place and they were just there for the thrill of the fight. On one occasion in 2010, I was working nights on C Wing, at approximately 22:00, when Graham Parnell (a DCM) came into the C-Wing office, and he asked for the paperwork for the person in room 12. This was a Pakistani male in his 40s who was being transferred to Dungavel House Immigration Removal Centre in Scotland. I knew that the detainee would not want to be transferred to Scotland because he had family in the Heathrow area. I asked Graham if I could speak to the detainee because I had a good relationship with him and I thought I might be able to persuade him to leave voluntarily. However, Graham wouldn't listen and decided that the detainee would be forcibly removed. The detainee resisted and was screaming for 45 minutes. He was placed in handcuffs, suffered a broken arm, and couldn't be transferred in the end because he required medical treatment. I felt ashamed of the behaviour of my colleagues. I spoke to the detainee the following day and he told me that had the process been properly explained he probably would have left voluntarily. Unfortunately, this was

part of the culture at Brook House and some colleagues took pleasure in the exercise of force.

158. About a month later there was a staff forum chaired by Ian Danskin (a Deputy Director). At this forum I suggested that in future with incidents of this nature, rather than seeking to remove a detainee with force, an opportunity should be afforded to an officer who may have a relationship with the detainee to speak with them to persuade them to transfer peacefully. The Deputy Director knew which incident I was referring to, but he didn't want to discuss it. He said, "I know the incident you are talking about, we are not going to discuss that".

159. I can recall another incident in approximately 2015 when dealing with an Egyptian national who had mental health issues. The detainee was given a written warning by a colleague for smoking in the centre and this triggered the detainee to self-harm by cutting himself. I was called to respond. I couldn't enter the detainee's room on my own because he had a blade, and a team was assembled to restrain him. The detainee then set light to his bin in his room and when the team opened his door, black smoke billowed out. I managed to recover the detainee by pulling him out of his room by his foot. The detainee was unconscious, and I commenced resuscitation before the healthcare team took over. A colleague and I had to attend hospital because of smoke inhalation. Afterwards I was asked by colleagues why I had pulled him out, (by which they meant why did you bother, because the detainee could be quite difficult and rude) to which I responded, "to save his life". I received a commendation from the Director and was nominated for a national G4S award for my actions.

160. This incident highlighted safety concerns. The sprinkler system was only triggered at a particular temperature (64 degrees Celsius), and not by smoke. In addition, there was a lack of availability of necessary equipment. In prisons, equipment is available that allows a room to be misted/sprayed to reduce smoke levels so that officers can safely enter. This equipment wasn't available at Brook House. The misting

machines also require an ingress point on all doors so that the machine nozzle can be inserted without needing to open the door, and the doors at Brook House didn't have this facility. Around the same time, money was being spent on adding 60 extra beds to rooms to increase the centre's capacity, instead of implementing necessary safety measures. It took four years to address this issue and it was only after Grenfell that someone in the Home Office required that misting machines were provided and ingress points on all the doors were installed.

161. I was injured at work on 17 January 2016 when a detainee smashed his television on the floor. The detainee was thought to be suffering from mental health issues and a decision was taken to move him to E-Wing. I assisted with the escort to E-Wing and during the procedure the detainee ran at me headfirst and injured my arm, spine and shoulder. I required hospital treatment and was off work for several months. I was not provided with the correct personal protection equipment (PPE), and I have an ongoing legal claim for compensation against G4S in which liability has been admitted. I aggravated the injury in 2020 when undertaking a control and restraint refresher course which has resulted in me being unable to continue to work as a DCO.

162. On another occasion, in approximately Spring 2017, a detainee was rude to a female colleague, and I advised him that his behaviour was unacceptable. The detainee punched me, and I suffered a glancing blow. A first response team was called. However, by the time the team arrived the detainee was already restrained. My colleague, Derek Murphy, was the first in and he punched the detainee while he was restrained. I managed to pull Derek away and I spoke to him afterwards and told him I was shocked at his behaviour and if I saw him do anything like that again I would report it. Derek accepted that he had lost it. Since this incident I have felt guilty for not reporting it, however, following the bullying and harassment I received for reporting the racist comment made by Sam Gurney, I was reticent to do so.

163. When I became a Welfare Officer, in 2016, I was rarely required to become involved in control and restraint work and I can only recall one occasion until the time I left Brook House.

164. The best alternative to control and restraint was the use of interpersonal skills. Use of force should always be a last resort. I sought to gain the respect of detainees through experience and the way I conducted myself.

### **Individual Welfare**

165. I had always wanted to be a Welfare Officer, but it wasn't seen as a priority at Brook House for some time. I became a Welfare Officer in the middle of 2016. The role had become vacant, and I applied for it. James Begg (my DCM manager) was overseeing the Welfare Department at the time, and he interviewed me for the position. After a few months in the role, I was seconded to the Home Office working on voluntary returns for 5 months, and I returned as Welfare Officer at Brook House around May 2017. The role had more prominence in my second spell at Brook House.

166. In the role I provided assistance to detainees (which included liaising with foreign embassies on their behalf and tracing missing property) and I signposted other assistance available such as legal advice, charitable organisations that could help with money and clothing, and the British Red Cross. The role was like a pressure release valve, and detainees were able to obtain some clarity about their immigration status, which helped because the stress of waiting and not knowing was considerable. I picked up the role from two other existing Welfare Officers, Terisha Crepin, and Octavian Stratt. There was no training provided before I started the role. You had to know about the bail process, and some immigration law, because the detainees had a lot of queries about the status of their cases. It was a very varied role and if you had some appreciation and knowledge of other cultures this made a big difference. In the 5 months I was seconded to the Home Office I learned more than at any other time because the role required that I knew the

immigration status of the detainees while seeking to arrange their voluntary return, and the detainees would often ask why they had been detained. My practice was to be honest and if I didn't know, not to speculate, and I advised colleagues to follow this approach.

167. Brook House now has 16 welfare officers. However, while I was in the role there were only 4 officers to deal with 1800 appointments a month, and the team was significantly under resourced. However, it is not simply a matter of more staff - those in the role of Welfare Officer need to have some experience of life within the centre, and also some knowledge of immigration process and procedure and it cannot be adequately performed by someone immediately following initial training. Once in the role there needs to be a structured process of shadowing an experienced Welfare Officer colleague, for at least a month. I also think that Welfare Officers should act as role models for other officers.

168. I introduced a practice of providing welfare services in the exercise yards at weekends, because this is where the detainees spent most of their time. There was some initial pushback from colleagues, but the Inspectorate of Prisons thought it was a good idea. A lot of the detainees were bored, and we helped just by interacting with them. I liked to be involved in the life of the building and the detainees responded to someone taking an interest in them.

169. Part of my role as Welfare Officer was to speak to the new officers and explain to them that the role of DCO required them to engage and build relationships with the detainees. I provided training on the role of a Welfare Officer as part of the ITC.

170. I recall an incident concerning the mental health of a detainee, around 2012, where I was required to assess an individual at the request of Nathan Ward. It was a re-assessment. An assessment had already been completed earlier in the day by a colleague, but Nathan realised that it had been quite cursory, so he asked me to carry out a re-assessment. I performed the re-assessment under ACDT and concluded that the detainee needed to be on constant observations. This sticks out for me because

the detainee was very quiet and didn't want to talk, and I can remember saying to Nathan that I wouldn't be happy going home until this detainee was on constant supervision. When this was communicated to the Oscar 1 on duty, he complained because this meant that an officer would have to be deployed to maintain constant observations. However, Nathan took on board my concerns and constant observations were directed, and the detainee was released the next day.

171. In my opinion, having worked at Brook House over a ten-year period, at least 20% of detainees were suffering from severe mental health issues, and approximately another 60% were suffering from minor to moderate mental health issues, such as depression, which was not unsurprising given their situation and their backgrounds. Staff simply weren't equipped to deal with people who were experiencing these issues, and this contributed to low staff morale and retention.

172. The training I received on mental health issues was very basic during the ITC in 2009, and we were given no real insight. The training dealt with the basic types of mental illness such as psychosis, anxiety, and depression, and the signs to look out for, such as withdrawal, aggression, and erratic behaviour. In 2014 when I re-joined, the training had improved and there was more depth and clarity.

173. As set out in paragraph 9 above, in 2016 I became accredited as a safer custody trainer, through a National Offender Management five-day residential course, together with four or five G4S colleagues. Following this training I was able to deliver introduction to mental health training to G4S colleagues, and to train colleagues to become ACDT assessors. We would provide introduction to mental health training on the ITC courses every 6 weeks or so, and refresher courses would be provided every two weeks or so. The emphasis on mental health training improved considerably from when I first started in 2009. The introduction to mental health training was of approximately two hours duration, and covered the different types of mental illness, including PTSD and issues of bullying. However, it did not cover de-escalation techniques or how to carry out an ACDT assessment (which

were part of separate training modules). ACDT assessor training was much more comprehensive and was delivered over a number of days with small groups of three to five colleagues who had expressed an interest in becoming accredited, and who usually had some experience already of working at Brook House. ACDT assessor training covered mental illness in much more detail than the introduction to mental health training, and it also dealt with issues of self-harm in detail.

174.I also provided inductions to healthcare staff on the ACDT process. I mention an incident when there was poor communication between the healthcare team and the DCOs on the Wing at paragraph 119 above. However, communication and collaboration improved over time, and if an ACDT log was opened because of mental health issues this would automatically result in a review by the healthcare team.

175.I do not think that healthcare staff had sufficient resources to deal with mental health issues. They would run a session called, “talking therapy”. This was conducted in the office next to my welfare office, and the appointments were back-to-back. They had three to four mental health staff and in my assessment, they needed more like 10, with additional resources available on call as necessary.

176.I have already mentioned above the use of drugs within the centre, and the policies and procedures for preventing them entering the centre. Drugs impacted significantly on the mental health of the detainees: including the side effects of the drugs (anxiety, depression, and psychosis); the reckless behaviour they would indulge in while under the influence; the violence that would ensue to control supply/turf wars; and worry over drug debts. There was undoubtedly a pervasive drug culture within the centre.

177.After the Panorama documentary an organisation called The Forward Trust started to provide drug rehabilitation. They would provide advice surgeries, group meetings, and educational information. This started to have a positive impact, but

the problem persisted. I was not aware of any involvement by the Forward Trust at Brook House prior to the Panorama documentary.

178. I worked closely with the chaplaincy. I sought their advice, and they would raise concerns with the welfare team. On one occasion a couple of nationals from Nigeria were praying loudly at night causing a disturbance to others. I asked the chaplaincy for advice, and they flagged a passage in the bible (about the merits of praying in silence) that helped resolve the problem. The main faiths represented were Christian, Islam, Sikh, Buddhist, and Hindu. The chaplaincy would make comments/observations in the ACDT log, and they would try to be present on the Wing inductions, to introduce themselves and offer their guidance and assistance. In my view they were a positive influence and they provided me with assistance and support in my role as DCO and Welfare Officer. I found that a knowledge of aspects of a detainee's faith could help when engaging with vulnerable detainees, for example the Islamic concept of Haram, which forbids suicide. The chaplaincy was also quite good about warning of potential radicalisation, for example groups who gathered and practiced their religion separately from others. Interestingly, given that there could sometimes be tension between different groups of nationals, I never experienced any religious tension within the detention centre.

179. Sadly, I have witnessed self-harm on several occasions. The procedure in response was to call a medical first response. The healthcare team would arrive, and the detainee taken to the medical room and placed under constant observation. An ACDT would be opened, usually by the person that identified the self-harm. An assessment would take place quickly (normally an ACDT assessment is required within 24 hours, but in the circumstances of self-harm you would try and carry out the assessment as soon as possible, although the detainee's welfare and wishes needed to be considered, and they may not be in a position to speak so soon after the incident, and/or may not want to). In the past I have carried out ACDT assessments in hospital when accompanying a detainee in need of hospital treatment. If other detainees and staff witnessed an incident of self-harm, their

wellbeing would also need to be considered because the incidents were shocking and disturbing.

180. The triggers for self-harm could be lost property, the cancellation of a flight, or because of the fact that a detainee was subject to detention. In my experience more people self-harm because of delays in their return, rather than because of being forced to return. Most people think that the majority of people who are detained do not want to return to their home countries but that was not my experience. I would estimate that 50% of the detainees wanted to return, and the things that were preventing them from returning were the difficulties in sourcing an airline, arranging escorts, and obtaining travel documents from the embassies of the country to which a detainee was to be returned.

181. After the ACDT assessment, it would be assigned by the Oscar 1 to a DCM case manager, and the case manager would determine the frequency of observations (constant, hourly, three times a day etc.), and an action plan would be put in place, which might include contact with family, legal and charitable assistance, welfare assistance etc. A review would then take place which might include input from the chaplaincy, the healthcare team, the Duty Director and the Home Office. Decisions would then be taken about whether observations should be maintained and whether a detainee could be returned from E-Wing to the residential Wings. We would try wherever possible to keep their old room available for them to return to.

182. Like many of the welfare measures described in this statement, the process for dealing with self-harm improved over time. When I returned to Brook House in 2014, I could see the improvement, for example, the role of Safer Custody Manager assumed more prominence. Tony Bond held this post initially, and he was responsible for the ACDT policy, the training of staff, and making sure the policies were complied with. When James Begg took over as Safer Custody Manager in 2016, he made further improvements, for example educating staff on the importance of an ACDT assessment so that other staff didn't consider it to be skiving (as had been the case when I first started to work at Brook House). Around 2017 the Brook

House Safer Custody Policy was considered to be one of the better ones within the prison/detention estate, and it received praise from the Inspectorate of Prisons. When I attended NOMs training I learned of some experiences from colleagues at HMP Birmingham, which had an issue with funding and staffing and a correspondingly high incidence of self-harm. In my view there is a clear link between these issues.

183. We would use all possible levers to help someone, so if a particular officer had a good relationship with a detainee who had self-harmed, they would be asked to engage the detainee in conversation.

184. I believe the policy and process was appropriate. However, for the process to be implemented effectively it is important for the staff to understand how important it was. If it is seen simply as an additional burden, then subtler warning signs can be missed. I believe the adequate training of staff in how to operate the process, and adequate staffing levels are vital to the success of the process and the safety of detainees.

185. One improvement that I would suggest is better communication by the Home Office because the detainees often felt in limbo. If their cases were processed quicker and they were updated more regularly on progress this would reduce their anxiety. Home Office caseworkers could also be educated about the practical impact of casework delays on the people who were being detained pending their outcome. When I was seconded to the Home Office, I would tell Home Office colleagues of the negative impact of delays on the detainees, which Home Office caseworkers wouldn't always appreciate, especially if they hadn't seen for themselves the impact this had on the detainees.

186. From my memory of working on the Wings up to 2016, the process for dealing with refusals to eat was that detainees would choose their meals for the following day from a menu which contained three or four meal options. These requests would be

sent to the kitchen and the meals would be provided by hand to the detainees and a record made when a detainee collected their meal. If a meal wasn't collected, then the detainee would be approached on the Wing and if they refused to take their meal a record would be made. Only lunch and evening meals would be recorded in this way. If a detainee refused meals on three consecutive occasions, then a food refusal log would be opened, and the detainee would be encouraged to eat. There were many reasons for refusing, for example, mental health issues, a dislike of the food provided, or in protest. Once a log was opened a DCM would be notified and a review would be carried out. Healthcare would also be informed and would speak to the detainee. The process could also be coordinated with the ACDT process. A lot depended on observations, and it was important to be out and about on the Wing so that you were abreast of what was happening with detainees, and you knew what was really going on. There could be evidence that a detainee was buying other food from the shop, and sometimes detainees would eat from the cultural kitchen sessions, which would reduce concern.

187.If someone stopped eating in protest, then they might be monitored and transferred to E-Wing. Chaplaincy might also become involved if appropriate. Healthcare would be heavily involved and in extreme cases hospital treatment might be required.

188.In my view the policy and process was appropriate, the issue, as mentioned above in connection with self-harm, is to ensure that staff are aware of the importance of proper compliance with the process. Again, this is an area that improved and received more attention following the Panorama documentary. The process was taken more seriously, and compliance (the recording of missed meals) was better. There was also more emphasis on the importance of complying with this process, and others, within the ITC and the refresher training.

**Detained Persons as time served foreign national offenders (TSFNO)**

189.I did not work on reception for TSFNOs.

190. I didn't treat TSFNOs any differently, but a TSFNO might behave differently, for example they might refer to DCO/DCMs as "guv", and they would also be quite attuned to whether an officer was experienced and knew what they were doing. TSFNOs could sometimes intimidate inexperienced and passive officers by refusing to comply with instructions and being rude and abusive. I found that my age and experience helped me in gaining respect from the detainees.

191. Occasionally a serving prisoner would be admitted to the centre for a Home Office interview, and they would be accommodated for a few days on E-Wing. The environment at the centre was almost always better than at prison and when it came time to be transferred back to prison, they would often become disruptive and resist. I thought this practice of bringing them out of prison for a few days was unhelpful, counterproductive, and caused unnecessary risks to detainees and staff because of disruptive behaviour and the potential need to use force.

192. To keep time spent in immigration detention for TSFNOs to a minimum I believe more should be done to arrange travel documents and a removal flight while the prison sentence is being served. I accept that some detainees will try to frustrate the removal process but there are others who spend time in immigration detention unnecessarily.

193. I don't think that TSFNOs should be accommodated with asylum cases and overstayers, both in terms of sharing rooms or within the same centre. Young, inexperienced detainees can be influenced adversely by TSFNOs who have been convicted of serious drugs and violence offences, leading to bullying, violence, exposure to drugs and gang culture, instruction in how to make weapons, being used as a guinea pig (when testing a new batch of drugs), sexual abuse, and extortion (inside and outside the centre).

194. We once had a boy band (a group of 5) from the USA on C-Wing for a few days prior to their removal, which in one sense is quite comical but reinforces the point

about how unsuitable and undesirable it is to accommodate people who have experienced issues with their visas, together with detainees who have been convicted of serious offences.

**Abuse of Individuals Detained at Brook House**

195.I have set out several examples of abuse by staff against detainees at other points within this statement. I can't remember any other specific instances.

196.There were sometimes problems with large groups of detainees of the same nationality. For example, on one occasion there were approximately 70 Chinese nationals at Brook House, and this resulted in a few violent incidents with other nationality groups. Whenever there were large groups of detainees with the same nationality, such as Albanian, Jamaican and Chinese nationals, they would try to exert influence, and this could often be connected to criminal activity (e.g. drug dealing) outside the centre.

197.Detainees who had been subjected to detention for longer periods were more prone to violence and there could be racial tension, particularly between eastern European and African national groups. Some individuals could behave in an intimidating way to other detainees, for example by pushing in the meal queue. Bullying and intimidation could also take place in and around the centre shop. Detainees would intimidate other detainees into buying them items from the shop. I can recall an occasion when a young detainee from Bangladesh was surrounded by several other detainees near to the shop. I intervened because I suspected he was being bullied/coerced.

198.I can also recall a dispute between a European national who seriously assaulted an African national, which was suspected to be connected to drugs. The European national was charged with a criminal offence and the African national required hospital treatment.

199. In the early years, between 2009-2013, fighting was more prevalent. I attribute this to inexperienced staff, the fact, as already mentioned, that the centre wasn't given chance to bed in, the Wings being open to each other, and the high percentage of TSFNOs (in 2009 it was 90% but in my second period at Brook House it was more like 50%). By the time of the Panorama documentary there had been a significant improvement with incidents of violence within Brook House.

### **Complaints**

200. The complaints procedure was that on every Wing there was a board which contained complaints forms in different languages. The complaint forms were posted within two metal boxes on every Wing, one for the Home Office and the other the Independent Monitoring Board, and they would be collected by a member of staff from those organisations. Home Office complaints were forwarded by the Home Office to Karen Goulder, the complaints manager at Brook House, to be actioned internally if appropriate. Karen would pass them to the appropriate team or person for a response. If serious the complaint would be passed straight to the Professional Standards Unit (PSU) for investigation.

201. If the complaint did not concern the welfare of an individual, it would be allocated to the appropriate team for a response, for example the activities team, or welfare team. If the complaint was more serious, for example verbal abuse, then an internal investigation would be commenced by a DCM. Serious complaints of physical assault would be passed to the PSU.

202. Early in my time at Brook House, in 2010, I was the subject of a complaint when instructed to pursue a detainee suspected of drug dealing. I was attacked by a detainee who tried to push me over the railings, and I had to strike him in self-defence. The detainee made a complaint which was referred to PSU. When I was interviewed by PSU the video of the incident was played, and it was clear that I was acting in self-defence. I could also be seen in the video pushing the alarm button to request assistance from colleagues because of the seriousness of the situation.

203. Detainees could approach any member of staff for assistance with completing a complaint form, and I provided assistance in this way on numerous occasions.

204. I am aware of one investigation outcome when an officer, who I believe to be Babatunde Fagbo, told a detainee, “go fuck yourself” and he was suspended and dismissed as a result. I understand that this incident was reported by a DCO colleague. My view of the process is that it didn’t always take account of the reality of daily life on the Wings. I accept that there is an obligation on staff to behave professionally but I don’t think that those responsible for adjudicating complaints were always aware of the considerable verbal and sometimes physical abuse to which officers were subject, and that under pressure, officers can sometimes act out of character, for example the behaviour of Clayton Fraser (mentioned at paragraph 142 above), and the comments of Babatunde Fagbo mentioned here.

205. A suggestion I have for improvement is not in relation to the complaints process itself, but to provide additional training on conflict resolution to avoid conflict in the first place and, as already mentioned, increased emphasis on recruitment to make sure that people with the necessary skills are recruited.

206. The complaint form had a separate section that asked whether the complaint was about healthcare in which circumstances the complaint was forwarded to the healthcare manager (Sandra Culver was the manager while I was at Brook House), and they would deal with the complaint. However, I have no other information about the process for complaints about healthcare.

### **The Panorama Programme**

207. I worked with Mr Tulley from late 2016 through 2017. He seemed to have a mature attitude and I had no issues with him. He asked my advice as a Welfare Officer on a few occasions. I heard a rumour that he was a “moonwalker”, which meant that if a disruptive incident occurred, he was slow to respond and assist. That wasn’t my personal view, just something I heard. I viewed him positively and that with more experience he would be a good officer.

208.I cannot identify myself on the documentary although I was working at Brook House at the time.

209.I knew that something like the Panorama documentary would happen, and early in 2016 the Director Ben Saunders warned that it would (the reason I can recall the date is because the warning coincided with the broadcast of a similar documentary concerning Medway Secure Training Unit. This Unit was also run by G4S, and Ben Saunders had worked there). A lot of staff felt betrayed and there was some negativity about Mr Tulley. Some were worried about what they might have said and what might have been captured on video. However, I recall my colleague on the welfare team, Terisha, saying to me, “have you noticed how much better things are after the Panorama programme”.

210.After the documentary some staff were worried about repercussions from the detainees. There was also a fear that there may be riots and I understand that response teams were placed on standby by the Home Office.

211.The Panorama documentary was almost a resetting of the clock, and while it was not a fair representation of the centre, for example it didn’t show how the officers would have a cup of tea with the detainees and play pool with them, it did highlight the problems.

212.A Home Office manager got in touch with me following the documentary because I had experience of Home Office focus groups. The Home Office set up some focus groups with detainees, and I attended together with colleagues from religious affairs and the chaplaincy team. The purpose was to provide information to detainees about the action that would be taken in response to the issues identified in the documentary. An investigation was promised, and it was explained that rogue officers were the cause. Many detainees commented in the focus groups that the incidents shown in the documentary were not typical of their experience, and that

in general they had been treated fairly, and that staff were helpful and polite. I took part in two or three focus groups (7 or 8 detainees in each group). I was also asked by the Home Office to engage with detainees on an individual basis to obtain feedback, and this was generally the same, namely that the documentary was not representative of their experience.

213. I wasn't aware of the young person shown in the Panorama documentary while I was working in welfare at Brook House. However, I am aware of the process for age assessment and have in the past referred cases to the Home Office direct, who would then refer the case to the West Sussex County Council for an independent age assessment to be carried out. The speed of an assessment depended on the resources within the council. While an assessment was taking place, I would recommend that the detainee in question be moved to E-Wing until the assessment could be provided. However, like the Rule 35 process, I do not recall receiving any training while at Brook House on the process for age disputes.

214. One impact of the Panorama documentary was that the staff who had been there the longest and who cared about the role were listened to more, by both senior management, the Home Office, and our colleagues. I mention within this statement numerous improvements that came about after the Panorama documentary, these are: increased staffing (including in healthcare), more emphasis on activities; the ACDT process and processes to ensure detainee welfare had improved before Panorama but continued to do so afterwards; introduction of The Forward Trust for drug counselling; and better communication and collaboration among the staff, particularly between the DCO/DCMs and the healthcare team. In general, the documentary made staff more aware of their own behaviour and that they were subject to scrutiny.

215. The Panorama documentary resulted in a negative perception of the centre, and Brook House has worked hard since to communicate a more accurate account of the conditions within the centre and the improvements that have been made. For

example, the centre invited visits from charitable organisations, and I can recall escorting members from a charitable organisation based in Dover, and they were pleasantly surprised at what they observed.

216. In 2018 an independent investigation into the events surrounding the Panorama documentary was commissioned by G4S. The investigation was carried out by an organisation called Verita and I was interviewed on 11 April 2018 as part of the investigation. I exhibit a transcript of my interview as OS2. Prior to the commencement of the investigation, staff were advised in a morning briefing, by Lee Handford (the Temporary Director at the time), that we should feel free to mention any issue of concern when engaging with the investigation and we were also encouraged to whistle blow.

217. It can be seen from the transcript, exhibit OS2, that many of the issues I have highlighted in this statement to the Inquiry I also raised in my interview, such as the importance of the role of Welfare Officer, the need for improved training, the importance of gaining experience on the Wings and in the centre, the value of the voluntary returns scheme, the need for greater resources, problems with staff retention, issues with racism, the existence of a macho and cliquey culture, and the lack of incentives and career progression for experienced DCOs.

218. In 2018 my senior manager Dawn Walker (Head of Safer Custody at the time) told me that a researcher from Oxford University, Professor Mary Bosworth (who I understand to be an expert to the Brook House Inquiry), would be attending Brook House to research a paper about how staff coped when working in a detention environment. Professor Bosworth spent a day in the welfare office with me and my colleague, Ben Opoku, and she observed our interaction with detainees. The following day I had a one-to-one meeting with Professor Bosworth, and we discussed issues connected to staff interaction with detainees and how some staff behaved differently to others. We discussed how staff might try and hide their lack of confidence and assurance with bravado, and I shared my own interest and views in this area. We also discussed how people can become empowered to behave

abusively within organisations when they know or believe that there will be no adverse consequences to their behaviour. Professor Bosworth also asked about the impact of the Panorama documentary. There was then a second one-to-one meeting a couple of days later.

219. The Inspectorate of Prisons also produced a report in approximately 2018 and I was also interviewed as part of this process. They were particularly interested in staffing levels in the welfare team, and they emphasised the importance of the role of Welfare Officer in their report.

### **Specific Individuals**

220. I am asked to comment on the individuals named below. My comments are limited to the behaviour and statements that I personally witnessed in my role as a DCO. I have not commented on the behaviour and statements of people shown in the Panorama documentary that I did not personally witness. My comments are as follows:

- a. **Nathan Ring** – Mr Ring didn't appear to show a particular interest in the role of DCO/DCM, and he did not seek to engage positively with detainees. He was not approachable to staff or detainees. His depiction in the Panorama documentary is an accurate reflection of my experience of Mr Ring's attitude and approach. I set out in paragraph 61 several derogatory comments he made about me. In addition to those incidents, I can recall another occasion in 2017 during a charter flight to Jamaica when three detainees climbed on the safety netting because they didn't wish to return, I was asked by silver command to intervene and to negotiate with them. As I sought to talk with a detainee and explain the assistance available in Jamaica, Mr Ring stood by smirking while I tried to negotiate, and he said to a colleague, "why did they send him in, what's he going to do, give them a cuddle?"
- b. **Steve Webb** – I worked with Steve (he was a DCM) and I only ever had positive views about him. I was shocked to see his behaviour in the documentary, and I believe he may have been having some personal issues in

his life at the time. He had commented to me about the pressures of the role and the person depicted on the Panorama documentary was not the person I knew. I thought that he was big hearted and compassionate individual, and the actions shown on the Panorama documentary were out of character. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.

- c. **Chris Donnelly** – I worked with Chris (who was a DCM) right from the very beginning. I had a lot of respect for him. He was consistent and fair and when he was in charge as Oscar 1, and I had confidence in him. He challenged me on one occasion when I was a little short with him on the phone because of the stress of the role I was experiencing at the time, and I apologised and respected him for doing so. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.
- d. **Kalvin Sanders** – I remember Calvin approaching me for assistance in the Wing office when he was new, to ask me for general advice in a situation where a detainee was behaving disruptively. I explained how I would approach it (stand my ground and listen) and he thanked me for my advice. However, I noticed over time that he began to associate with several of the officers who would engage in laddish behaviour. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.
- e. **Derek Murphy** – I refer to an incident above at paragraph 162 when Derek punched a detainee. This incident occurred in front of new staff, and I asked him to think about what kind of example he was setting. He was a confident and assertive individual and many of the younger officers looked up to him.
- f. **John Connolly** – I worked with John for a long time. He was based at Tinsley House. I can recall one occasion at Brook House when detainees were queueing

for food, and he mistakenly accused a detainee of pushing in the queue in a heavy-handed manner (rather than seeking to de-escalate the situation) which almost caused a major disturbance.

- g. **Dave Webb** – I did not have much to do with Dave. He became a control and restraint instructor and I understand that he was dismissed for comments he made during a personal protection course. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.
- h. **Clayton Fraser** – I mention the fact that Clayton’s conduct on the Panorama documentary was out of character at paragraph 142 above, and I wonder whether this was to fit in with the culture at Brook House (as he was normally based at Tinsley House). I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.
- i. **Charles Frances** – I worked with Charles quite a bit and found him to be a good officer who was supportive of detainees. He worked on E-Wing in a challenging environment, and he received a nasty bite from a detainee about 6 months before the Panorama documentary. I have commented elsewhere in this statement on my view that as officers we were not given sufficient training to deal with detainees who were suffering from serious mental health issues, and Charles would be someone who would be particularly exposed to these issues on E-Wing. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.
- j. **Aaron Stokes** – Aaron was a young officer who did not seem particularly interested or committed to the role. However, I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.

- k. **Mark Earl** – I got on well with Mark and he quietly and effectively got on with the job. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.
- l. **Slim Bassoud** – I know Slim very well. He had a relaxed attitude and was not the sort of person to talk badly to a detainee. He was from Tunisia and spoke Arabic and would always assist detainees. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.
- m. **Sean Sayers** – I knew Sean from when he first started at Brook House. He had a good rapport with detainees. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.
- n. **Ryan Bromley** – I do not recall this person and cannot comment.
- o. **Daniel Small** - I do not recall this person and cannot comment.
- p. **Yan Paschali** – Yan was an ex-prison officer who had worked at Wandsworth. He had an air of superiority and would not take advice from other officers. However, I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.
- q. **Daniel Lake** – I do not recall this person and cannot comment.
- r. **Babtatunde Fagbo** – I have known Babtatunde from our ITC together in 2009, and I mention him in connection with a disciplinary issue at paragraph 204 above. He was of Nigerian heritage and some detainees could take exception to this (the fact that as a foreign national working in an immigration role). I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him.

Witness Name: Owen Syred  
Statement No: 1  
Exhibits: OS1 and OS2

- s. **Shane Munro / Monroe** – Shane was a female officer who was not at Brook House that long. I know that she had a dispute with another officer in connection with an allegation of a racist comment that was made by the other officer against her. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with her.
- t. **Nurse Jo Buss** – I had no issues with Ms Buss. I cannot recall witnessing any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with her.

### **Suggestions for improvements**

221. In my view a much-needed improvement would be to make staff (particularly DCOs) feel more valued, and to introduce a form of career progression within the grade of DCO, so that experienced DCOs can be rewarded for doing a good job in that role and will regard it as profession rather than just a job for a wage. This will also assist with staff retention. Consideration should also be given to a professional qualification such as an NVQ in custodial settings.
222. I also believe that it is important to ensure that Welfare Officers have the appropriate skills and experience for the role, which requires knowledge of life on the Wings, knowledge of immigration processes and procedures, and adequate and appropriate training. It's not just about the numbers (I believe that there are now 16 Welfare Officers at Brook House) it's about having the right people in the roles, because of the importance of the work of a Welfare Officer.
223. Low levels of staff retention with many leaving after only a short period is a huge problem and very costly in terms of the time and resource spent on repeated recruitment and training. It would be far better in my view to have a more rigorous recruitment process, with more emphasis on mature committed candidates who wish to pursue and build a career in this field of work.

224. I learned a lot through my secondment to the Home Office and I would strongly recommend more training and education for detention centre staff on immigration process and procedure because as a DCO/DCM you are basically living with detainees for whom these issues are the primary concern, and a knowledge of the process and of their circumstances is a significant benefit when seeking to engage and build relationships and trust.

225. There should be more emphasis on the role of a DCO/DCM as carer, rather than on control and restraint.

226. The job description is not an accurate reflection of the role. DCOs are not prepared for the fact that they will be dealing with people with serious mental health issues, self-harm, and the traumatic issues that some of the detainees have experienced, and the levels of aggression shown towards them, and they aren't given the tools to do the job.

227. In addition, the support for staff who can be significantly adversely affected by their experiences in the role needs to be improved. The care team do provide support and can be approached by staff to discuss any difficulties that staff are experiencing, however, the support is not very comprehensive. It's also difficult to speak to people outside of the centre because without experience of the issues that arise in a custodial setting, it's difficult for people to appreciate and comprehend the circumstances.

**Any other concerns**

228. The way in which Sam Gurney and others appear to have become radicalised with racist and negative views about detainees while working within immigration detention is a big cause for concern.

229. Connected to this is a tendency for compassionate and kind individuals to behave negatively towards detainees, out of character, potentially because of a desire to fit

in with the prevailing culture at the centre. There are several examples of this type of behaviour in the Panorama documentary.

230. I believe that staff can be negatively conditioned by other staff, and they can also be negatively influenced by public opinion (for example negative views towards immigration), and I think there should be more action by the Home Office and the organisations that manage immigration centres to combat these influences through rigorous recruitment, training and perhaps monitoring of social media (as I mentioned in my interview with Verita, exhibited as OS2, I am aware from Facebook that some colleagues were connected to right wing groups, such as Britain First and Knights Templar).

231. The majority of my comments and observations within this statement are made from memory, and I am happy to provide further information with reference to specific documents if requested by the Inquiry.

232. In 2019 I challenged two officers on separate occasions within weeks of each other, because they were commenting about how much they enjoyed control and restraint work. I raised these issues with Sarah Newland (a Deputy Director), without mentioning the names of the officers, because I was concerned that things might be slipping back to the culture that existed prior to the Panorama documentary. Following the Panorama documentary, I was more confident that my concerns would be taken seriously.

<p><b><u>Statement of Truth</u></b></p> <p>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.</p> <p>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.</p>
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Witness Name: Owen Syred  
Statement No: 1  
Exhibits: OS1 and OS2

Name	Owen Syred
Signature	<b>Signature</b>
Date	16/11/2021

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