BROOK HOUSE INQUIRY

First Witness Statement of Kye Clarke

I provide this statement in response to requests under Rule 9 of the Inquiry Rules 2006 dated 5 July and 1 November 2021, and to a further request by email dated 13 January 2022.

I Kye Clarke, of an address known to the Inquiry, will say as follows:

Background

1. I have roughly 3 years' experience as a Detainee Custody Officer with both Tascor and as a Detention Custody Officer with G4S (Tascor transported immigration detainees and foreign national prisoners from one detention centre to another, to immigration tribunals, and to airports for removal). I started with Tascor in June 2014 and left in October 2016. I was then employed by G4S between October 2016 and August 2017 as a Detention Custody Officer (DCO). The main reason for moving from Tascor to G4S was because the job with Tascor involved a lot of driving and there could be significant delays with traffic which caused me to work longer hours. The hours with G4S were more certain and it was easier to plan a personal life. However, I enjoyed the work with Tascor which is why I decided to remain in the industry. I used to get on quite well with the detainees and I would ask them about their lives. I found it helpful to build a rapport because the circumstances of the detainees were difficult and stressful and if, for example, a bail application was refused then they could become quite upset.

2. However, shortly after starting work with G4S, shortly before Christmas 2016, I became unhappy in my role as a DCO at Brook House because of the stress of the role and I started looking for other work. I was suspended in the Spring of 2017

in connection with an incident which is detailed at paragraphs 69 to 73 of this statement and I resigned from G4S in August 2017. I currently work as a Technology and Customer Service Assistant.

Application process

3. As already mentioned, I enjoyed my work with Tascor and Brook House offered a similar line of work without the long hours of travel. The recruitment process involved an online test for English and Maths. There was then an assessment day with team exercises, problem solving and an interview. At the conclusion of the assessment day, I was told I had been successful and was given a start date for initial training. There were a large number of applicants. Most successful applicants appeared to be young. I was 29 when I joined G4S and most people were younger than me.

4. In terms of preparation for the role, the recruitment process was informative, and I already had some insight of the nature of the role from my time with Tascor. Although nothing can really prepare you for the daily life and the reality of being on a Wing at Brook House with approximately 150 detainees with only one G4S colleague (on occasion there would be more but for most of the time it was just two DCOs on a Wing).

5. There was a very high turnover of staff, in particular a large percentage of new staff left within a short period of their start date, and I suspect this was because the reality of the role was very different from their expectations.

6. I was originally meant to be based at Tinsley House, but it was under renovation and closed for much of my employment with G4S. However, I did work there a few times. When I did it was empty with no detainees so I would ask the Detention Custody Manager ("DCM") on shift if I could attend Brook House and assist colleagues there, as my presence in an empty building was a waste of a shift.

Culture

7. I mainly worked on A-Wing which was busy all the time. The DCO I worked with most was Gus Olyaie. We were very fair with detainees, and we did our best to accommodate them in the time we had available. As well as manning and patrolling the wing, we had to escort detainees to reception, carry out room searches, provide essential items such as toilet roll, facilitate access to fax machines, and help detainees with reading documents.

8. There was no significant change in the way that A-Wing operated over the period I was employed. The DCOs on A-Wing were referred to as Alpha 1 to Alpha 5, with Alpha 1 being the most experienced and Alpha 5 the most inexperienced (although there were not always five DCOs on the Wing). Within approximately two months of my start date, I became the Alpha 2, the second most senior DCO on the Wing (Gus was the Alpha 1). I was moved into this role so quickly because of the high turnover of staff. The probationary period was 4-6 weeks and there was a review at 6 months.

9. Right from the start it was obvious that there was a problem with low staff morale due to low staffing levels and high staff turnover. New people had to quickly adjust, and the staff seemed drained and stressed.

10. While I was at Brook House there were a number of medical emergencies due to spice being smoked. Some detainees would have seizures, or be physically sick, and some required resuscitation. There was so much of it smoked it would give me a headache on occasion. It started to become a big problem in November 2016 and by December it was chronic. Over 2 days in Christmas 2016 there were over 30 medical emergencies due to spice. It reduced slightly in 2017 but remained a problem through the whole period I was at Brook House. The medical emergencies made the job significantly more difficult.

11. A minority of detainees would on occasion be threatening, aggressive and violent towards DCOs, and DCOs would be wary of these individuals. I got on with most detainees. I can recall one detainee who assaulted me by pushing on two occasions. However, following his release from detention I had a chance meeting with him, and he apologised for his behaviour, which he explained was due to the stress of being detained.

12. No one was particularly safe, staff or detainees, as weapons could easily be made, from toothbrushes, razor blades, the broken ends of brooms and the metal poles from the showers. Someone even made a knife from a paperclip and crisp packets by melting the packets into a lump and filing a sharp edge. We would find weapons through searches of rooms.

13. Staffing always seemed stretched. On one occasion I can recall a fight between two detained persons which escalated to a large group of detained persons ganging up on one of the detained persons and I was the only DCO in the vicinity (I was on the first floor and an inexperienced colleague was on the third floor). The detained person (first detained person) who was attacked by the group was former military personnel and was short but fairly stocky from what I remember. I believe the incident occurred on Delta Wing. The first detained person was at the communal sink washing his crockery when another detained person (second detained person) tried to push in and use the water. The first detained person warned the second detained person to wait. The second detained person emptied the contents of his plate over the first detained person's clean crockery, and the first detained person punched the second to the side of the head. I was standing by the sink and tried to split them up when the second detained person called out to his friends on the Wing. About 20 of them tried to attack the first detained person with me in the middle trying to push them back. I called first response and backed up with the first detained person to the rear of the building where we exited through the emergency exit and I locked the door. This incident occurred between

December 2016 and May 2017. The availability of more DCOs and Detention Centre Managers (DCMs) to contain these incidents was required.

14. Detainees with mental health issues were assessed by a member of the healthcare team. If a detainee was identified as being at risk of self-harm they would be transferred to E-Wing where they could be monitored and observed more easily.

15. Violent and disruptive detainees were transferred to segregation and once the period of segregation was over (normally 24 hours) a detainee would be transferred back to the main Residential Wings, A, C and D (B was for new detainees). However, if there wasn't sufficient space on the main Wings they could be accommodated on E-Wing until space became available, which was not appropriate in my view because many of the detainees on E-Wing were vulnerable. Some detainees with serious mental health issues would be transferred out of the detention centre.

16. Senior management did not attend the Wings often but did visit E-Wing and Segregation to assess the detainees there. They would also review detainees, together with the DCMs, who were subject to the Assessment Care in Detention and Teamwork (ACDT) procedure. ACDT was a method for recording relevant issues relating to a detainee, such as risk of self-harm, disruptive behaviour, and signs of torture. An ACDT log would be opened if a concern was identified in connection with a particular detainee and for so long as the log was maintained each DCO would update the log while on their shift. The records were made by hand and were also a useful means of providing an update for DCOs coming on shift. Senior managers would review the ACDT logs together with DCMS and decide whether a detainee should continue to be monitored through ACDT.

17. Every morning there would be a briefing. The briefing would usually be delivered by Jules Williams (the Residential Manager who I believe was part of the senior management team) and the Director, Ben Saunders, was often present. This would

include information about imminent removals and the next charter flights, and particular issues of concern such as detainees who were on hunger strike.

18. I do not know or remember much about what exactly the senior management team did at Brook House.

19. I remember a detainee who was shown on the Panorama documentary who seemed too young to be in adult detention. When another DCO and I mentioned this to the DCM we were told that the Home Office had said he was 18 and that is what was recorded on his IS91 (the IS91 is the Home Office authorisation to detain). The DCM we spoke to said that they could not change the decision, and it was down to the Home Office. The issue was escalated to senior management and the Home Office.

20. The DCOs did what they could for the detainees. On one occasion I identified that a Rastafarian detainee who was new on the Wing had particular dietary needs (he was vegetarian due to his religious beliefs). As DCO I was responsible for submitting a list setting out the number of meals required on the Wing. This detainee arrived on the Wing after the list had been submitted and in these circumstances, he would have received a standard Halal chicken meal. However, I recognised that this would not be acceptable to the detainee, and I arranged for his meal to be changed. The detainee wrote to the Director of Brook House when he was released in praise of me for welcoming him in this way, which resulted in me receiving a voucher in recognition.

Physical layout of Brook House

21. Brook House was designed like the letter H and was 3 floors high. Wings A, C & D were 3 floors high while B-Wing, which was for new detainees, was 2 floors high, as E-Wing and Segregation were underneath B-Wing. Typically, a new detainee would spend a few days or a week on B-Wing before being accommodated on A, C or D Wing. All rooms had access to natural light. The air

was recirculated and often got stale and the smoke ventilation hatches on the roof were opened frequently during the spice pandemic and on hot days. Technically, detainees were not allowed to smoke within Brook House. However, in practice it was tolerated within their rooms because of a fear of rioting.

22. More natural light would have helped to improve the morale of both staff and the detainees. Also, the look of the detention centre resembles that of a prison and had a negative impact on the atmosphere. Each Wing had its own exercise yard and was usually open and detainees of all Wings, except E-Wing, could congregate in A, C or D yards. However, detainees could not access a Wing other than their own, without special permission.

23. Other improvements that could be made are more sports or activities to keep the detainees entertained. Each yard a specific activity, for example, football goals in C-Yard, Cricket in A-Yard and a seating area for D-Yard. However, there is scope for more.

24. Because of the physical layout of the building not a lot can be changed within the centre.

25. E-Wing was for detainees who were subject to ACDT and required additional supervision and monitoring, as it was difficult to provide the necessary supervision on a normal wing of 150 detainees with just two officers, particularly if they required regular observations (for example every 15 minutes) or constant observation. Detainees on E-Wing were given access to the exercise yard for about an hour a day which was less than other detainees who had access 09:00-12:00, 14:00-17:00, and 18:00-20:30. This was because they needed additional supervision and because the physical layout of Brook House, which meant that E-Wing detainees had to travel through Segregation to get to the exercise yard. Staff would also escort a detainee from E-Wing to the yard for a cigarette. The ratio of detainees to staff on E-Wing was better than that on a regular Wing and E-Wing

might have three, four, or five DCOs depending on the number of detainees needing regular or constant observations.

26. A DCM would authorise the transfer of a detainee from E-Wing back to the regular Wings if they were satisfied that they no longer posed a risk to themselves or to others and that they could be integrated back onto the regular Wings. As part of this process, consideration would be given to whether the detainee could be paired with a friend, or with someone of the same nationality, or with the same religious beliefs, or a trusted detainee, to help the detainee should they start to get upset and to inform us if there was a risk of self-harm.

Policies and Procedures

27. The policies and procedures were discussed during the training. The main procedure was ACDT. While employed at G4S I had access to the policies and procedures in hard copy, but it is difficult for me to now recall specific details without having sight of them. Most staff followed the policies and procedures. There were some that would take their phones past the entrance to Brook House, which was not allowed, and this was reported to the DCMs and the Security Team, but I do not know what action was taken. I do not remember if the policies and procedures were updated during my time there.

28. Some of the procedures such as checking the detainees ID every time they went out of the Wing caused unnecessary stress because the detainees would complain about having to do so. This policy was strictly enforced by Jules Williams who threatened DCOs with disciplinary action if we did not follow it. I informed Jules of the difficulties this policy was causing and that it was often unnecessary because we knew most of the detainees very well, having spent over 12 hours a day with them for weeks and months. However, Jules insisted that the policy was followed, and I was assaulted by a detained person on two occasions as a direct result because the detainee thought the policy was petty and unnecessary. This is the detainee I refer to in paragraph 11 above, who subsequently apologised for his

behaviour which he attributed to the stress of being detained at Brook House. The detained person's surname was D349, and he was an Iraqi national. This policy did not take account of the realities of working at Brook House.

General Training

29. I started initial training in October 2016, I do not recall the exact duration, but it was a number of weeks. My main training was split between 2 trainers, a lady (Vicky) who was heavily pregnant, and a male officer (Santiago). Vicky was only present for half of the training. Most of the training was provided above the entrance to Brook House. The use of force and personal protection training was in an Army Reserves building in Crawley, and also partially in the dojo to the left of the Brook House entrance. Other subjects covered in the training were the ACDT process, first aid, fire training, and report writing. There were a few other subjects which I cannot now remember.

30. The training was sufficient, though I would have liked it to have been a little longer so that we could get a better understanding. However, as mentioned, nothing could prepare for the day-to-day reality of life inside the centre which was full on every day and a steep learning curve.

31. I also think the training should have included a longer shadowing period where we could properly shadow an experienced colleague. Because the centre was so understaffed, I rarely got the opportunity to observe an experienced colleague performing aspects of my role during the shadowing period. I seem to remember that the period of my shadowing was only a week, but I may be mistaken. I know it wasn't very long.

32. I don't have a specific memory of a refresher course. I may have done one, but I can't remember the subject. I think refreshers ought to take place every 6 months.

33. I did not work with the activities officers and cannot comment on their training.

Personal Protection Training

34. Part of the initial training included some personal protection training (I seem to remember it being one day's duration) and was taught by the same officers as the use of force trainers. I do not remember any refresher courses. The training was provided well, it was taken seriously and made enjoyable to learn.

Use of Force

35. Use of force training was provided as part of my initial training in October/November 2016. I do not remember any refresher courses or being offered any refresher courses. The training was very good, it allowed us to focus on the steps to take, and to experience different scenarios. I believe the use of force training lasted for about a week. These sessions were both group and one-to-one with instructors. The instructors were helpful and would advise us if we did something wrong. This training included control and restraint techniques. I did not receive any additional use of force, or control and restraint training while employed by G4S. In my opinion the training equipped a DCO to perform their role.

36. I have been asked to comment on MMPR training with reference to document CJS005623, which states that I did not receive MMPR refresher training within the six months prior to 21 April 2017. I was employed by G4S in October 2016 which will explain the absence of any MMPR refresher training in the six months prior to April 2017. Further, I did not receive any MMPR training, which I understand to relate to working with families at Tinsley House.

37. I have also been asked whether a set number of warnings were given to detainees before force was used. Before any use of force, efforts would always be made to de-escalate the situation and to seek compliance with a request, which could take 30 minutes or so. However, I am not aware of a set number of warnings that had to be given prior to the use of force.

The role of a DCO and relationships with detained persons

38. I got along well with most of the detainees. I dynamically assessed the detainees with whom I engaged (this was a technique that I learned at Tascor that encouraged you to pick up on physical and verbal signals). I approached the detainees as normal people and would try and build rapport. I strove to get along well with the detainees, particularly those on my Wing.

39. Some detainees that did not speak a lot of English normally had a fellow detainee that would translate for them, and Gus Olyaie (the Alpha-1 on A-Wing) spoke Arabic. We did have an interpretation line although we rarely used it, as the detainees would rather a friend interpret for them. A-Wing had a high number of Jamaican detainees. They were particularly mistrusting of the Home Office and would see DCOs as working in conjunction with the Home Office. I worked hard to build trust with the detainees by finding subjects of common interest to discuss, and by being helpful where I could. In this way I was able to gain the respect of the detainees and would happily meet with them again.

40. I would play pool with the detainees, and when out on the exercise yard I would take part in some of the activities, such as cricket and football, to build rapport and encourage participation. We would often have a good laugh with the detainees in this way.

41. I do not remember any specific incentives for a detainee to behave while inside the detention centre. There were jobs for which a detainee could earn money, such as working in the kitchen, cleaning the floors, gardening work, and canteen work serving food. Sometimes detainees could be asked to act as an interpreter if the official interpreter wasn't available. There needed to be more jobs as they were popular. Those that had jobs were informed that if they breached the rules, they would have their jobs taken away, although this wasn't strictly enforced.

42. As mentioned above, the ACDT process was used to monitor detainees at risk of self-harm or who were otherwise vulnerable. The process annoyed some detainees as they felt like they were always being watched. We used it to record events or comments that a detainee had made and any changes in their demeanour. As mentioned, this was a useful process to enable the next DCO on shift to be made aware of any risks. I believe the ACDT process was effective, and the managers regularly reviewed the records.

43. Actions taken for preventing the use of drugs in Brook House were the random and targeted searches of staff and detainees. During my time at Brook House there was rumour that a staff member (a female cleaner) was bringing drugs into the centre. I understand that this person's car was searched but nothing was found. There was also a rumour about a DCO who had been seen smoking a glass pipe at work (which is associated with drug taking).

44. I was personally subject to several random searches. Sniffer dogs were brought in to try and tackle the problem. Most of the targeted searches of detainees were not successful. I suspect that the detained persons who were responsible for dealing drugs rarely kept them in their rooms and used associates/accomplices to store them.

45. The visitor centre is the main area that drugs were brought into the centre. I witnessed a detainee conceal a wrap in his trousers and he was removed from the visiting hall where he was searched. The wrap was identified, although due to its location on his person (he had stored the wrap up his anus and part of the wrap was visible) we were not able to recover it.

46. I did not work as part of the welfare team. I would regularly ask one of the members of the welfare team to visit with a detainee when they requested assistance. Most of the issues raised by the detainees were about updates from the Court/Tribunal or Home Office. As with other areas of Brook House the welfare

team needed more staff as the main welfare officer, Owen Syred, was always busy trying to help the detainees where he could.

47. I was not part of the security team, though I would contribute Security Information Reports, for example intelligence from detainees about who was bringing spice into the centre (which may then result in a targeted search).

Relationships with staff

48. Prior to the Panorama documentary, I was not aware of any racist behaviour or attitudes by staff. The documentary was the first that I had heard of it. However, detainees would frequently say that they had only been detained because of the colour of their skin.

49. I was not aware of any homophobic behaviour amongst staff.

50. The only sexist behaviour that I can remember was during my training. A person on my training course, Name Irrelevant said that because women were not built like men, they couldn't defend themselves, and he made other inappropriate comments. Together with three women who were also on the training course, we raised these issues with the trainers, and as a result of persistent inappropriate behaviour, he was removed from the course.

51. I was not aware of any confirmed case of staff bringing drugs into the centre.

52. I experienced bullying behaviour from two members of staff, a man and a woman who were in a relationship. They would criticise my appearance and clothing and made other personal comments. I requested that they stop making these comments and when they did not, I reported their behaviour to a senior manager, Dan Houghton. I was told that a DCM had spoken to the male member of staff, but no other action was taken, and their behaviour continued, and I was labelled a "rat" for speaking out. Other officers heard their comments, but no one would come

forward as they did not want to get involved. Their behaviour occurred from January to May 2017, and contributed to me wanting to leave Brook House.

53. I can remember a dispute between two female DCO colleagues and I offered to be a witness for one of the parties, who I had witnessed being subject to inappropriate behaviour from the other. I encouraged my colleague to report the inappropriate behaviour to a DCM, but I was not asked to make a statement. However, again, no action was taken, and I believe the person who made the complaint resigned as a result.

Relationship with Home Office staff

54. I did not have much contact with Home Office staff. Some seemed devoid of emotion and empathy when delivering bad news to detainees, for example when a detainee had exhausted all their appeals and they were told that they were to be removed from the UK. We were not normally in the room with the detainee when the meeting was taking place unless we were requested to stand by.

Relationship with senior managers

55. I did not have a high opinion of Jules Williams (the Residential Manager). I thought he was rude and unsupportive. I have set out above at paragraph 28 his insistence that we continue to check the identification of detainees even though we knew them well and in circumstances where this was causing tension with the detainees. I had very little contact with other senior managers (Ben Saunders the Director and Dan Houghton, who I understood to be the second in command at Brook House). The only time I was called up to the director's office was to be congratulated on doing a good job because a detainee had written a letter that stated that I had made his stay at Brook House as pleasurable as possible, and I had been easy to talk to (this is the detainee I refer to in paragraph 20 above).

56. I cannot comment on the availability of the senior management team as I was mainly on the Wing, and I could not leave it. I would like to think that they were

approachable and my experience with the Director, Ben Saunders, was that he was. I had no particular issues with them or with the way they dealt with detainees. They seemed fair when I witnessed them speaking to detainees in Segregation.

Relationship with DCMs

57. I do not remember the name of my direct manager as they changed sometimes. The main DCM I dealt with was Steve Dix, just because he was the most present on the Wings. He had a particular way of dealing with the detainees that was firm when needed, but he also enjoyed banter. If a detainee or detainees had caused an issue during the day, he would sometimes chat with them at lock-up to clear the air and make sure there were no underlying issues.

58. The quality of the management seemed ok. I did not have much to do with them as I would normally be doing the daily tasks on A-Wing or manning the door to A-Wing.

59. There was rarely a need for feedback in connection with most day-to-day routines and the DCMs were normally busy. However, I would have liked their presence more often on the Wing as some days were very challenging.

60. During my probation period I had a meeting in the HR rooms with a number of the DCMs, Jules Williams, and another person. There were no issues identified with my work.

Relationship with other DCOs

61. One of the main issues at Brook House was the high turnover of DCOs. Frequently I would not feel safe with a certain DCOs on the Wing because of their inexperience and lack of confidence. My fears materialised one day when I was attacked with a broken pool cue. The DCO I was working with was renowned for being unreliable in such situations and when he saw me being attacked, he locked the door to stop other people walking into the situation. This was the correct thing

to do, but he then failed notify the other DCO on the Wing of the incident. The detainee then tried to stab me in the chest with the broken pool cue. I managed to secure the detainee by leaving the area, leaving him locked in the hallway. I suffered an injury to my arm and lost feeling in my arm and fingers for several weeks. I also suffered an injury to my chest. Immediately after the incident I was seen by a nurse at Brook House and later I required hospital treatment.

62. This incident is the same incident that is described in document CJS005623, and my statement of the events within CJS005623, dated 21 April 2017, is at pages 19 to 22. The use of force was reasonable and proportionate. There was no further investigation to my knowledge.

63. While working at Brook House I would always act to protect my colleagues and detainees.

64. I have been asked to comment on document CJS005478. I have no recollection of the incident referred to in this document and I do not believe that I had any involvement. I suspect my name is included on the form because a colleague used an earlier report as a template and failed to remove my name.

Relationship with Healthcare Staff

65. The healthcare staff would open and give the detainees on the methadone program their medicine and then at about 09:00-10:00 they would walk round the centre with the senior managers and the DCMs to assess detainees who were subject to the ACDT process.

66. With planned use of force and first/medical response someone from the healthcare team would be present. They would observe the detainee and sometimes talk to them if they had a rapport with them.

67. Most communication between DCOs and the healthcare team would be in connection with the ACDT process, regarding medication, behaviour triggers, and self-harm issues.

68. The only time I witnessed healthcare staff become frustrated with detainees was during December 2016 when large numbers of detainees were smoking spice which caused seizures and placed a burden on the team. It was the same people over and over again, and one detainee smoked it three times in one day and required medical attention on each occasion. Around Christmas Day I remember hearing that one detainee was given CPR in a room on D-Wing.

Disciplinary and grievance processes

69. I was subject to a disciplinary investigation in June 2017 in connection with the restraint of a detainee. The detainee had climbed onto the wire safety netting and was threatening to self-harm by cutting himself. His roommates told me that he had taken his razor apart that morning and was threatening to cut his wrists if he was not released from the detention centre. The detainee would periodically come down from the netting but if the DCOs approached him he would climb back on again. This happened on about six or seven occasions. On one occasion when the detainee had climbed off the netting, I travelled up the backstairs and I was able to physically restrain him. To do this I had to remove my belt with my keys so that he couldn't hear me coming. I managed to take hold of the detainee as he attempted to climb back on the netting and pulled him backwards towards me, so that the detainee landed on top of me.

70. My account of this incident dated 22 May 2017 is at page 15 of document CJS005927, and at pages 9 and 10 of document CJS005618.

71. At all times I acted in the best interests of the welfare and safety of the detainee who had threatened self-harm, and my use of force was reasonable and proportionate.

72. The detainee made a complaint against me, and I was suspended pending an investigation for taking my belt and keys off and for restraining a detainee without the assistance of at least two colleagues.

73. The police investigated the incident and concluded, in document SXP000039 that it was, "clearly not in the Public Interest to pursue any further", and that there was, "a justifiable use of force and the minimum required (no injury to detainee)".

74. Following the incident with the pool cue I had started to look for alternative employment and I decided to resign from G4S prior to the determination of the disciplinary proceedings. G4S did not comply with the time limits for carrying out the investigation (the investigation was not carried out in accordance with the time limits stipulated and at the point of my resignation it had been ongoing for approximately 8 weeks). The stress of the investigation made me very ill for several months. Following my resignation, the disciplinary proceedings were never formally completed.

75. During my investigation, information was relayed to me from colleagues about confidential discussions that had taken place during the investigation, and I raised a grievance in June 2017 about this breach of confidentiality. I was never provided with a response to this grievance. I cannot recall how I raised the grievance, email or letter etc. While I was suspended, I was only allowed to contact Jules Williams as my Liaison Officer. I could not get in touch with him, and he only called me twice the whole time I was suspended. I do not recall being informed by G4S how to raise a grievance, and I believe that it was my union representative who advised me to do so. In the course of my preparation for this witness statement the Inquiry has provided to me a copy of document CJS000473, which records that at the date of my resignation, the investigation of my confidentiality grievance was ongoing.

76. I also raised a grievance around April 2017 against the two DCOs who I mention in connection with allegations of bullying in paragraph 52 above. I had wanted to resolve these issues informally but as the bullying and inappropriate behaviour

continued, I requested a formal resolution. Again, I was never provided with a response to this grievance. I do not remember the method by which I raised the formal complaint.

Staffing levels

77. The staffing levels always seemed to be low and 2-3 staff on a Wing was the average, usually with at least one inexperienced DCO. There were about 150 detainees on each of the regular Wings (A, C & D) and often only two DCOs, as the third officer would usually be reassigned elsewhere within the centre, for example, to help staff the visiting room or provide support on E-Wing for constant observations.

78. If a competent DCO was reassigned, leaving an inexperienced DCO to manage the Wing, morale would suffer. Effective shadowing was not possible as it was hard enough to get the daily tasks done as well as assist the detainees with their queries. Sometimes the computer room or the exercise yard could not be opened as there was not enough staff and so there might only be one of three exercise yards available.

79. Lunch times were challenging, and a few times detainees would fight over the lunch line or when washing their plates and cutlery. Competent DCOs would be aware that issues could arise quickly, and they would be on hand to help resolve them. It was not uncommon for staff to eat their own lunch in the office (rather than the staff canteen) so that they would be on hand to help resolve any issues between the detainees and to provide colleagues with support, particularly inexperienced colleagues. An example of this (a DCO eating their lunch in the office) can be seen on the Panorama documentary. Sometimes I would only take 30 minutes of my lunch and return to work early to support the officers on the Wing.

80. Short staffing was a major contributing factor to a lot of problems faced by the DCOs on the Wings. The days were long (sometimes 14-15 hours) and a lot was expected. In my opinion, two or three more DCOs on each Wing was required to perform the role professionally, which would have enabled DCOs to devote more time to building relationships with the detainees. The issue of staffing levels was raised constantly by most if not all DCOs, to DCMs and senior management. I personally did so on numerous occasions and the answer was always the same, that a new set of officers were being recruited, but within three months of arrival most if not all would have left.

81. From what I know the healthcare team was not understaffed. Although on occasion there could be several people waiting to see the team which could sometimes cause tension between the detainees. Most detainees could access healthcare as and when they wanted but on occasion, they needed to book an appointment or return when it was less busy.

82. There was a need for more staff in the activities team as regular DCOs sometimes had to cover the computer room because the activities team were short staffed.

Tinsley House Staff

83. Tinsley House is split into two parts, one being a family unit, and the other for detainees who had not been convicted of offences of a violent or sexual nature. The numbers of detainees at Tinsley House were about half those at Brook House. The atmosphere in Tinsley House was calmer as a result, and if a Tinsley House detainee was disruptive, they would be transferred to Brook House. Tinsley House staff did not like Brook House because the atmosphere and behaviour of the detainees at Brook House was much more challenging. All DCOs, whether at Tinsley House or Brook House, received the same training, other than those working in the family unit who required specialist training to work with families and children.

Treatment of Detained Persons

84. I personally got along well with most of the detainees and would quite happily meet with them again. I could name a few that I got on particularly well with. When detainees came into the centre, they would be seen in the waiting room and once searched they would be moved to the secure waiting room, where they were be offered a meal and a hot or cold drink. They would then be seen by the doctor or nurse before they were sent to a Wing. Depending on how busy the reception was or if there were removals taking place, some detainees would need to wait longer than normal. I only worked a couple of half shifts on reception, where I searched detainees when they entered the reception and then offered them hot meals and drinks.

85. I am asked to comment on the induction policy document. However, this has not been provided to me and I am unable to do so.

Activities for individuals

86. I don't feel that there were enough activities, and tournaments to keep the detainees occupied, although staffing levels would have needed to be increased to staff the yards. Cricket and 5-a-side football competitions could have been more frequent. Cricket was very popular on A-Wing, and I would frequently get the stumps, bat and tennis balls out ready so they could start playing straight after breakfast.

87. Another improvement that could be made is to extend the lock-up time to allow detainees to watch televised major sporting competitions together on their Wings, rather than in their rooms. There were occasions when detainees would be watching a football match together and they were required to return to their rooms for lock-up halfway through. To allow the detainees to watch the matches together would require additional staffing in the evenings but this would help improve the atmosphere.

Immigration Rule 35 Process

88. The only involvement I had was to report any signs of self-harm and behaviour or statements made by detainees of concern. For example, if there were indications that a detainee may have been subject to torture or if the detainee stated that this was the case. This information was recorded on the system and brought to the attention of a DCM.

89. I do not remember much regarding the review process, but I do recall that on reception detainees would sometimes refuse to see the healthcare team or their appointment would be postponed until the following morning if they arrived late.

Use of force

90. Use of force was not used that often. I can recall two occasions while I was at Brook House and several more where I was instructed to wear protective equipment, but the exercise was cancelled prior to deployment.

91. The first occasion was not long after I started in about October/November 2016 and was a planned no notice removal to escort a detainee for a flight. I was wearing full personal protective equipment and was designated to secure the left arm. From what I remember I pinned the arm, and the detainee was possibly put in a wrist lock and escorted to E-Wing where he was handed over to escort officers. The detainee didn't resist much once restrained. The detainee's flight/deportation was later cancelled, and he was back in the detention centre within a few hours. There was a debrief and we were told there were no issues from what I can recall. The use of force was reasonable and proportionate. The detainee would have been given an opportunity to comply with the removal request and the incident would have been recorded on a body camera.

92. The second occasion was similarly in relation to a removal. However, on this occasion the detainee was more compliant and only guiding holds were used.

93. I do not believe that use of force was excessive at Brook House. It was used as a last resort and most of the time the DCO or the DCM would speak to a detainee and de-escalate the situation. This was the main alternative to use of force and the best tool we had.

94. I feel that the control and restraint package at Brook House could be updated and that the use of a restraint belt would avoid more than necessary force being used, although this equipment was not available at Brook House while I was there. Once the belt is secured on the detained person this minimises the amount of force required and is safer to transport the detained person, especially during escorted removals.

Individual welfare

95. We all received training in mental health issues in the initial training. The ACDT procedure was the main thing I remember. Detainees with mental health issues were subject to the ACDT procedure, and if a detainee exhibited signs of depression, self-harm, suicidal thoughts or other mental health issues, or if their behaviour changed, they would be placed on ACDT pending review.

96. I think more training should be provided to help staff better understand mental health issues and how we could appropriately engage and help detainees who were experiencing these problems, particularly as it is such a significant issue and most cases of depression go unnoticed. I am not aware if refresher mental health training courses were offered, and I did not personally request additional training while I was employed by G4S.

97. I do not remember too much regarding the attendance of detainees with mental issues at healthcare. I do know that all detainees were assessed when they entered the detention centre, but I was not part of the reception team. I can recall one detainee who was transferred to a hospital for treatment for mental health issues,

and he returned to the centre a few days later. However, the detainee was not on my Wing, and I do not have any more information about the circumstances.

98. All detainees could see the healthcare team when they wanted. Those with mental health issues were regularly reviewed by the healthcare team or a DCM depending on the severity – the more severe the more frequent the reviews. The healthcare team did have a registered mental health nurse who would review the detainees and the ACDT logs. The nurse was always polite and softly spoken. I am not aware of any complaints about the care provided.

99. Drugs entered the centre in various ways; via visitors, stitched in clothing and in the soles of trainers, etc. As already mentioned, during December 2016 spice was rife and it was a particularly bad batch that made people very ill. It was rumoured to be laced with heroin. Over two days between Christmas Eve and Boxing Day there were over 30 medical emergencies relating to spice. In addition to risks to health from the drugs, this impacted negatively on the culture and atmosphere within the centre.

100. On a separate occasion, a Vietnamese detainee had boiling water poured over his back and suffered severe burns, which was rumoured to be connected to a drug debt. I was told about this incident by other officers. Not long after returning from hospital he was using spice again, and I attended a couple of first response calls as a result of the detainee suffering from the affects of the drug. It was not possible to stop the detainee from using spice and he seemed to go straight back to smoking it. Although the detainee was not resident on my Wing I am fairly sure that he was subject to observations. However, unless the observations were constant this would not prevent a detainee from obtaining and using spice, and there were too many detainees who were using spice to constantly monitor all those who were suspected of doing so. The date of the incident was most likely to be December 2016 at which time the use of spice was particularly high. However, I cannot

remember with any certainty, and it could have been any time between December 2016 and May 2017.

101. There were some drug rehabilitation programmes available, however, the ease with which drugs entered the centre coupled with the environment within the centre meant that they were not particularly effective.

102. We were taught in our initial training how to conduct a thorough search and as far as I am aware we all did our best to stem the flow of Spice. However, drugs still entered the building. The main ways of controlling this were through searches and scanners. Detainees who were under the influence of drugs were given first aid if required and escorted to E-Wing for monitoring. I do not remember any specific first aid training to deal with people who were under the influence of drugs. For those who were unresponsive we would check airways, breathing, and circulation (ABC) and place them in the recovery position.

103. The chaplaincy was a source of support for detainees. The main person I dealt with from the chaplaincy was the Imam who seemed to help calm the detainees. The chaplaincy rarely, if ever, spoke about detainees to the DCOs unless it was relevant to the ACDT log in which circumstances they would sometimes write up the log. The conversations were private detainee's room and frequently in Arabic.

104. Detainees that spoke of self-harming, attempted self-harm or self-harmed were subject to the ACDT process and this was reviewed by a DCM. I do not fully remember the process. Once an ACDT process was initiated in respect of a particular detainee the officers on the Wing would be briefed, told of any triggers for the detainee and most monitoring would be hourly or 3 times daily (at which point the log would be updated). The log would also be updated in response to any specific issues of concern. I did not personally witness an incident of self-harm.

105. I think the ACDT process was effective, but as mentioned it could cause irritation with some detainees because they felt like they were being watched.

106. When detainees collected their lunch or dinner there was a sheet with all of the detainees' names and we would tick off those that collected their food. Then we would note down the names of the detainees who did not collect their food. Sometimes a detainee may not be present at the centre because of attendance at an Immigration Tribunal. For those who were present in the centre but had not collected their food we would go to their room or find them elsewhere in the centre to find out why. If the detainee didn't eat for two days, we would open an ACDT log and when they collected food or when we saw them eat, we would note it down in the ACDT log. Sometimes detainees would not collect their food because they or their friends worked in the activities kitchen, and they would cook food in addition to the normal meals and share it on the Wing.

107. If a detainee refused to eat for a prolonged period, they would be subject to the ACDT process, and senior management and the Home Office would be made aware of the situation and consideration was given as to whether detention could be continued.

Detained persons as time served foreign national offenders (TSFNO)

108. I did not work on reception and cannot comment on their processes, however, the more information we had on a detainee the better because we were able to understand their circumstances and deal with any issues they were experiencing. An absence of information did not normally cause delays in processing as far as I know. A detainee's history might be a factor when deciding to pair detainees in rooms.

109. I did not treat TSFNOs any differently than other detainees. I built a rapport with most of the detainees. Once you gained their respect, they would not cause you any issues. However, I would check and be aware of their history for background and risk assessment purposes.

110. I feel that those that had served sentences for offences of violence should not be accommodated with overstayers. Tinsley House is normally where the overstayers would go but it was being renovated at the time (it was being renovated in October 2016 when I joined and there was a staggered re-opening from March/April 2017) and so it was not possible to accommodate detainees there while the renovations were taking place. Although, when the centre did reopen some low-risk detainees refused to go to Tinsley House as they wished to remain with their friends at Brook House. Tinsley House had less capacity than Brook House and even when it operated at full capacity it was still necessary to accommodate some overstayers at Brook House. However, there were rarely any major issues when accommodating overstayers and TSFNOs together. The most common complaints were from detainees who wanted their own room.

Abuse of individuals detained at Brook House

111. I did not have any concerns about detainees being physically or verbally abused by staff and did not know of it until the Panorama documentary, which was after I had resigned from G4S.

112. The only concerns about abuse between detainees were drug related. When we searched some rooms, we would find information (for example a list of debtors and the amounts they owed) or weapons that appeared to be linked to the collection of drug debts and threats of violence to obtain the payments. It was common for detainees to verbally abuse each other and if it got particularly heated a DCO would tell them to pack it in. However, the majority of it was street talk (cussing and slang) between groups of friends.

Complaints

113. There was a whistle-blower telephone line for staff to report incidents and behaviour to a third-party organisation. DCOs could also speak to a DCM. This

was meant to be confidential, but my experience was that confidentiality was not maintained. An officer who left Brook House not long after I started told me that they had raised a complaint about a DCM and their life was made harder. Whether this was due to a lack of confidentiality with the whistle-blower line I do not know, but I did not trust it, and if I had an issue, I would take it up with a DCM or higher. Internal investigations were assigned to senior manager.

114. I do not have any faith in the complaints process as I made complaints about bullying and a breach of confidentiality (see paragraphs 75 and 76 above) and they were not addressed.

115. It is difficult to comment on improvement of the processes because I do not remember them. But if I had to add something it would be that the process should be confidential, and not disclosed to other members of staff, as in my case, and if confidentiality cannot be maintained within Brook House then managers from other G4S centres should carry out the investigation.

116. I do not remember the process for detainees to make a complaint. However, the welfare team would listen to detainee complaints and Owen Syred (Welfare Officer) would normally be the one to speak to the detainees.

117. I am asked to comment on document CJS000651. Row 33 of this document refers to a complaint made by a detainee against me for issuing two warnings within a short space of time. The complaint was upheld in relation to the first warning because the warning was issued the day after the incident occurred. The complaint was also upheld in relation to the second warning because the timings on the warning form post-dated the time at which the detainee was locked in his room by several minutes. With regard to the second warning, I can recall that the detainee was inciting other detainees not to lock up. The time discrepancy on the form (a matter of 10 minutes) is likely due to the fact that I completed the lock up, and then completed the warning form. I note that the investigating manager found that the detainee was lucky not to have been issued with more warnings as he had

been spoken to on 13 occasions by 11 different members of staff, which suggested that I had not picked on him as alleged. I do not recall the policy and process in place for issuing warnings.

The Panorama programme

118. I rarely worked with Callum Tulley as he was in the activities team. However, I remember him.

119. I was not able to see or identify myself in the Panorama documentary.

120. I had resigned prior to the airing of the documentary. However, I believe the Panorama documentary would have had a negative effect on morale. Most of the officers are genuine people who try their best in a very tough and demanding job with limited resources, staff shortages and a high staff turnover. The documentary shows the officers when they were exhausted and frustrated with the spice pandemic - once one batch was gone another variant would come in, and each caused their own unique symptoms. I was shocked to see and hear some of the behaviour of the DCOs and the DCM shown in the documentary. However, while I accept that some of the comments were unacceptable and inappropriate, some were out of frustration, and it felt like all officers were being tarred with the same brush because of the actions of a minority of individuals.

121. Regarding the individual who states that he is underage, this detainee was a commonly mentioned subject by the staff as he looked underage, and I refer to him above at paragraph 19. However, the information provided to the centre about his age on the authorisation for detention form, IS91, was that he was 18. It was raised by numerous DCOs to the point that a DCM came to the office to confirm that they were aware that the detainee looked underage, and it had been escalated to senior management and the Home Office, and that we were to stop asking about it. This is why you can hear some officers on the documentary saying that they were not going to mention it, because it had already been brought to the attention

of senior management and we had been told there was no need to raise the issue again. If the Home Office determine a detainee's age at 18 or above, a DCO or DCM cannot change that decision. All we could do was raise a concern, which is what was done.

122. My understanding of the route of escalation for concerns about a detainee's age was that it was through a DCM to senior management and on to the Home Office. As I mention at paragraph 19 of this statement, I raised this specific issue with a DCM, and subsequently a DCM came to the Wing and requested that Officers stop mentioning it because it had already been escalated to the Home Office.

123. I cannot comment on any changes and improvements following the documentary as I was no longer working at Brook House when the documentary aired.

Specific individuals

124. I am asked to comment on the individuals named below. I worked at Brook House between October 2016 and June 2017 and my comments are limited to this period and 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** - I did not work with him directly, he was not normally on my Wing, and I rarely had contact with him. When dealing with detainees he was firm when they were being aggressive or rude but would otherwise assist them if he could. I do not recall any derogatory, offensive, or insensitive remarks, or any verbal or physical abuse while working with him.

b. **Steve Webb** - I do not recall the name and cannot comment on this person.

c. **Chris Donnelly** - I do not recall the name and cannot comment on this person.

d. **Kalvin Sanders** - He was a new officer. I did not work with him often as he was on another Wing. He seemed to have a cocky attitude and demeanour and was not someone I would have liked to have on my Wing as his attitude could have made some situations on my Wing a lot worse.

e. **Derek Murphy** - I worked with Derek a few times on E-Wing. He was firm but fair when detainees would become abusive and aggressive but would also help those that requested assistance. He was mainly based on E-Wing and when the spice pandemic started it was not uncommon for all of E-Wing to be full with detainees requiring medical treatment from the effects of spice. I do not recall any derogatory, offensive, or insensitive remarks, or any verbal or physical abuse while working with him.

f. **John Connolly** - He was the trainer for Use of Force and I rarely had any contact with him. I cannot recall any derogatory, offensive, or insensitive remarks or any verbal or physical abuse while working with him, including in training.

g. **Dave Webb** – He was an officer on E-Wing, I never had any issues with him, and I cannot recall any derogatory, offensive, or insensitive remarks or any verbal or physical abuse made while working with him. He was frequently helpful to the detainees on E-Wing when I worked with him.

h. **Clayton Fraser** - He would frequently assist on A-Wing during lunch times. He was competent, always polite, and courteous to detainees when I was present. I cannot recall any derogatory, offensive, or insensitive remarks or any verbal or physical abuse made while working with him.

i. **Charles Frances** - I do not recall the name and cannot comment on them.

j. **Aaron Stokes** – I believe he was a new DCO but I cannot remember anything more about this person, and cannot comment on them further.

k. **Mark Earl** - I do not recall the name and cannot comment on them.

l. **Slim Bassoud** - The name Slim is familiar. I believe he may have been based on D-Wing but I cannot remember anything more about this person, and cannot comment on them further.

m. **Sean Sayers** – He was a new DCO and had a good rapport with detainees and would be courteous to them whenever I was present. I do not recall any derogatory, offensive, or insensitive remarks or any verbal or physical abuse made while working with him.

n. **Ryan Bromley** – He was a new DCO on C-Wing. He was helpful to detainees whenever I was present and I recall one occasion I attended C-Wing that a couple of detainees told me that he had been helpful and kind to them. I do not recall any derogatory, offensive, or insensitive remarks or any verbal or physical abuse made while working with him.

o. **Daniel Small** - I do not recall the name and cannot comment on this person.

p. **Yan Paschali** - He was based on E-Wing and I did not work with him much. He would come across as intimidating in the way he spoke to detainees and colleagues, and in the way he carried himself. However, I cannot recall any specific comments.

q. **Daniel Lake** - I do not recall the name and cannot comment on this person.

r. **Babtatunde Fagbo** - I worked with him on some occasions and had no issues with him nor the way he dealt with detainees while I was there. He was a

competent and reliable DCO. I cannot recall any derogatory, offensive, or insensitive remarks or any verbal or physical abuse made while working with him.

s. **Shane Munro / Monroe** - I do not recall the and cannot comment on them.

t. **Nurse Jo Buss** – In all the times I have escorted detainees to her I cannot recall her ever being rude to any of them. I cannot recall any derogatory, offensive, or insensitive remarks or any verbal or physical abuse made while working with her.

Suggestions for improvements

125. The main improvement I would recommend is more staff, and better-quality staff. It was concerning knowing that you could not always rely on a colleague (for example the incident with the pool cue at paragraph 61 above). The new recruits also need to have more life experience.

126. The second improvement would be the quality and quantity of the meals. This would frequently cause discontent with detainees who would say that they were still hungry after meals.

127. As mentioned by Lord Ramsbottom in the Panorama documentary, the length of time detainees are held inside the detention centre is too long. It is meant to be a short-term holding facility. It is also not fair that some detainees are held in the centre for almost two years because their country of origin is not recognised (Palestine) or does not accept returns (Zimbabwe).

128. When foreign national offenders start their prison sentence, they should be informed that they also face automatic deportation, so that they can resolve their immigration status and minimise the time spent inside Immigration Removal Centres.

Statement of Truth

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

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

Name	Kye Clarke
Signature	**Signature**
Date	27/01/2022