BROOK HOUSE INQUIRY

First Witness Statement of David Aldis

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 15/06/21 and 10/03/22.

I, **David Aldis**. will say as follows:

Introduction:

1. I have been a Detainee Custody Officer since January 2009. Towards the end of 2016 I became a seconded Team Leader (the name was later changed to DCM Detainee Custody Manager) and whilst seconded I worked mostly on B Wing as a residential manager. I held this seconded position until it was made substantive in 2018. I then became an Oscar 1 and held this role until a new contractor (SERCO) took over the contract at Brook House. I am currently a DOM (same job different title) with Serco.

Background:

2. I joined G4S working at Brook House when the contract first started in 2009. It was my first proper job and prior to that I had worked in a club and a sports shop. What initially attracted me to the DCM role was the better shift pattern and the better salary.

Application process:

3. The recruitment process didn't prepare me for the role, it consisted of a Maths and English based test on-line and then competence-based questions in an interview. I got a seconded position after the 2nd attempt of the recruitment process and then it took a further 2 more interviews to get the substantive DCM role.

4. The training for the DCO role consisted of 6 to 7-week training plus testing. We didn't have the benefit of work shadowing at the time as it was a brand-new centre and there was no-one to shadow. As I recall, 120 of us started at the same time. I don't think anything can prepare you for the job until you do it. It was hard. Everyone was new up to senior management level. There were a couple of

prison officers but many of the staff were new and inexperienced. There were naturally teething problems and we learned and improved through trial and error. Because we didn't have much control the residents at the time took liberties, but it was so long ago that I don't really remember the detail.

Culture:

5. I didn't feel that there was a particular identifiable culture at any time. I came to work, did my job as best I could and then went home at the end of the shift. I feel this was the same with most staff. I feel we all did what we could do and helped residents the best we could during their stay with us at Brook House.

6. Throughout my career at Brook House staff morale was up and down just as it was immediately prior to and during the relevant period. Some staff enjoyed their jobs, and some didn't. Some staff liked the shifts some didn't. Morale was affected by low staffing levels and lack of experienced staff. After Panorama, morale was down largely due to feeling let down by staff members who had been seen acting in these awful ways. All staff felt they would be tarnished with the same brush and worried they would receive backlash for other people's actions. Attitudes towards individuals detained at Brook House have not ever been bad from my experience.

7. At the time I didn't have any concerns about the companies' values or the culture. In my view, the people we looked after were looked after well.

8. The staff were not always treated well by the company, poor shift patterns were set in stone, staffing levels were low and our concerns were not listened to.

9. During the period and time before, mental health was never really explained and no training was ever given on how to deal with and or see mental health issues.

    (i) The lack of training made dealing with detainees with mental health difficulties very difficult and challenging. The lack of training affected my ability to carry out my role when dealing with mentally unwell detainees.

    (ii) The lack of training on this topic was raised many times, by many staff, including me. Because of the passage of time, I cannot recall how, when and to whom I reported it to. Ordinarily, the issue would be raised with mangers after difficult incidents involving mentally unwell detainees.

10. I can't say there was a culture for management and leadership within the senior management team. We definitely never had any support from them, they worked 9-5 and then went home no matter what was happening. Leadership were accessible if went up to their offices. We could go and see the Senior Management team but they were not visible on the ground. Anything staff asked

for tend to get a yes answer but then nothing ever came of the yes. For example, requests concerning shift patterns or things we needed to do the job such as IT equipment - even small things like a replacement chair for a broken one was never actually actioned.

11. I was never aware or became aware of any occasion where someone raised a concern about the treatment of individuals informally or as a whistleblower until staff were informed of the upcoming Panorama Documentary.

Oversight, monitoring and outside involvement:

12. I don't seem to have a copy of the HMIP inspection (VER000116) to answer 13.a and 13.b.However, I wouldn't have had any direct involvement in that inspection save to answer to answer any questions that were asked. As I understand it, findings are published online and normally before it is published it is shown to us. From 2015 onwards action plans were put in place. If there were actions I needed to carry out I would be told what we have to do and what we have done.

13. In my capacity I never received a complaint regarding victimisation of detainees by staff.

14. I understood the IMB to be an independent set of people who are there to help detained individuals with any issues they feel are not being sorted by either the contractor or the Home Office. Any interaction I had with them was pleasant and positive. Whether it was a general chat about what was happening within the centre, the general mood, whether there was anyone that they needed to be aware or wary of or who they needed to talk to, or simply them asking in passing for directions to a certain area or individual's room. I wasn't involved with them on a formal basis.

15. I understood the Gatwick Detainee's Welfare group to be a charity who bought in clothes for individuals who had nothing, as well as phone top ups. They also used to visit individuals who had no one to visit them. I had very little interaction with them, and never had any concerns with them.

16. Medical Justice I knew very little about other than they occasionally came in and examined individuals whose solicitor asked for a second opinion. I can't say I remember any contact with them.

17. Bail for immigration detainees were a group that helped individuals with the bail forms and applications. Again, I never had any contact with them.

18. I cannot think of any other external organisations at present.

Physical Layout of Brook House:

19. I don't believe the physical layout of the centre had an impact on the care of detainees or the general atmosphere.

20. I don't think any changes could be made to improve care of individuals, maybe having windows could help individuals feel more comfortable in the room at night or even having their doors open at night but these types of things can't and won't happen for security reasons. The building needs to remain secure and the Home Office determine when detainees have to be locked up and unlocked. Unfortunately, things can't be made any different to make anyone more comfortable.

21. When the extra beds were introduced to the ground floor rooms, at first the individuals residing in the rooms were not happy as there was already very little space in the room for 2 people let alone 3. It would also mean another 20 or so individuals sharing the open association area which would make it busier and louder. Staff were not keen on the idea for the same reasons as well as having added concerns for the staffing levels which were already low. Having any extra 20 detainees would make the work-load larger. Either way it wasn't happily welcomed by staff or detainees alike.

22. E wing was used for many reasons over the years, mainly for vulnerable individuals, individuals with medical issues, individuals who had a flight the following day and sometimes for individuals coming off of rule 40 from segregation, to test their compliance. The reason for being on E-wing would determine whether or not they were allowed off the wing to use the centre facilities. It was different to being on the other wings due to the size of the unit and the smaller amount of individuals on it. I can't say I remember there being a set 'criteria' to be met for admission. At that time, I think healthcare would decide if there were healthcare reasons for potential admission, and the DCMs if there was an age dispute or an individual needed to be moved there because they had a flight the next day. At the relevant time I had only been a DCM for a month or two and during most of my time during that period as a DCM I was a I was a residential manager so a referral to e-wing was not my decision at the time. Generally, the Oscar 1 or 2 or the Duty Director make that decision. With regard to removal from e-wing, again I was not responsible for that decision, but I believe that decision was taken by Healthcare, the Duty Director and/or DCM.

    (a) I have reviewed CJS0074003 which shows that: (i) on 4 August 2017 I decided that, after assaulting a member of staff, D642 should remain on E-wing with no access to the Centre during association times and; (ii) on 5 August 2017 I noted: *'Afternoon access only. Continued good behaviour + compliance possible all-day association 7/8/17.* I do not recall this incident and, therefore, I cannot explain how I came to decide on the degree of access to the centre. Document CJS004362 provided guidance from G4S in relation

to '*Removal from Association*'. Detainees subject to Removal from Association (Rule 40) had restricted freedom of movement and access to the facilities available in that unit. They were not given the freedom of movement that other detainees had. This acted as an incentive to conform to the Detention Centre rules.

(i) I cannot recall the incident and, therefore, I cannot confirm why I considered that, on 4 August 2017, no access should be allowed to D642. However, it was not uncommon to restrict full access in these circumstances.

(ii) D642 was granted some access on 5 August 2017, presumably because his behaviour had improved to warrant such access. In addition, granting some access was a way to monitor the detainee's behaviour and test their compliance with the Detention Centre rules.

23. I have reviewed CJS004778_02 where Ben Opoku gives a description of D2244's behaviour on 21 July 2017.

(a) I do not recall this incident and, therefore, I cannot confirm whether Mr Opoku's account is accurate.

(b) I do not recall this incident and, therefore, I cannot explain whether I took the decision to move D2244 for medical observations and/or the reasons for such a decision.

(c) I do not recall this incident and, therefore, I cannot confirm whether I subsequently reported this incident to healthcare save to say that I would ordinarily do so and that this would be noted on the Operations Handover report.

(d) If Healthcare requested that a detainee be moved to E-wing, I would endorse that request. Ordinarily, I would not undertake a separate assessment.

Policies and procedures:

24. With regard to the Policies and Procedures highlighted by the Inquiry in their rule 9 request I can comment as follows:

a. DSO 21/2012 Room share risk assessment was drawn to my attention at some point in my employment, but I cannot pin-point when. It has and was used by staff and me on a regular basis.
b. G4S Gatwick IRC Incentive scheme policy - I cannot remember anything on this.

c. G4S detainee reception and departure policy 2016 – this would not have been introduced to me during initial training as I started in 2009. It is however used now regularly by staff and me.
d. G4S Gatwick IRCs general security Risks Policy - I can't recall when this would have been bought to my attention, but I can say it is used by myself and by staff.
e. Assessment in Care and Detention Teamwork – this was show to me on my initial training course It's a comprehensive policy and took at least a day's work to go through. As I recall we were broken down into small groups – someone would do the training and we would go through the policy. Now 3 days are dedicated to it. It is used regularly by all staff.
f. Supported Living Plan - this was not shown to me at the start of my employment but was introduced later and is used on a regular basis by all staff.
g. Minimising and managing physical restraint was introduced on my initial ITC and was and is used regularly.
h. Violence Reduction Strategy was not introduced from the beginning of my employment however it is in effect now by staff when needed.
i. Removal from association (rule 40) care and separation unit policy, I cannot remember if this was originally drawn to my attention at the beginning of my employment or not, but it is regularly used by myself and staff.
j. Age dispute policy again I cannot remember if this was introduced to me at the beginning of my employment which was over 11 years ago now. It is used regularly currently.
k. DSO 03/2015 handling of complaints was not originally drawn to my attention at the beginning of my employment but was when I became a DCM. It is still used by staff today.
l. Home Office Detention Service order on management of adult at risk (2017) would not have been introduced to me at the beginning of my employment as I started in 2009. It is used by me and staff now.
m. Gatwick IRCs Drug and Alcohol strategy 2017/18 would not have been part of my initial training. I can't say it was regularly used by staff or myself. A new policy has now been rolled out to be used as of 1 September 2021.
n. Regime and activities policy - I do not remember being introduced to me at the start of my employment but it is regularly used by self and staff.
o. Removal from association policy 2016 – this would not have been shown to me at the start of my employment as I started in 2009 but it is used by staff and myself regularly.
p. Detention services order 02/2017 removal from association and temporary confinement. Again, as I started in 2009 this wouldn't have been part of my initial training. A removal from association policy is used today regularly by staff and me. The Temporary Confinement element has been removed although I cannot recall when. It would have previously been in use, but I don't recall when it was introduced.

q. Home office detention services order on care and management of detainees refusing food and fluid – this was not introduced to me from the start however there is a current policy being used by staff and myself daily.

25. New policies would have been introduced either by a notice to staff or by another DCM or my line manager telling me about it or through a toolbox talk. We were encouraged to read new policies and sometimes there would be checks by managers. I thought the policies functioned well and took into account the realities of working at Brook House. I have never had a part to play in the updating of policies so cannot comment on this. I don't feel that there are any issues with updating them. In my view the policies reflect what happens on the ground.

Training

General training

26. I took part in a 6-week training course when I joined G4S at Brook House in January 2009. I started working in Brook House in April 2009 as a DCO, when the building opened. The 6-week course covered a large number of areas. As I recall we covered control and restraint, first aid, health and safety, detention centre rules, IPS (interpersonal skills) training (how to talk to people – how to communicate – barriers to communication in this type of work) self-harm and suicide training (ACDT). I can't remember what else the training comprised of as it was so long ago. I did not receive any further training for when I was employed as a DCM. I wouldn't have had input into DCO training and induction at that time.

27. The training gave me a basic understanding of what to expect. However, Brook House was a brand-new centre and all the staff were brand new to the job. The start was hard work due to the fact there were no experienced staff with knowledge of how to run a centre.

28. I believe more on the job training/shadowing is needed before staff are fully able to undertake the job and I feel this should be undertaken before the initial training course. Many people complete the ITC and have no real knowledge if the job is for them until they step foot in the building. Other than shadowing beforehand there is no way of preparing people for the job fully, in my opinion.

29. I have never had any input on training courses.

30. Refresher training for Control and Restraint has always taken place every year. General refresher training came along a few years after my initial start and since it was introduced it has taken place yearly and since 2020 (after Serco took over the contract) this has been a 2-day course and pretty much covers all aspects of training. This course includes a lot of aspects of the job and is useful. It is an

improvement on the previous 1-day refresher course as that was not really long enough to refresh everything.

31. I don't believe there was any different training for activities officers. They would have been told what to do by the activities DCM.

Managerial Training

32. I had no extra training when I became a DCM, I shadowed another DCM for a week or so and was then left to it.

33. Since the dates in question, I have completed a diploma in leadership and management paid for by G4S.

34. More training about policies, procedures would have been helpful as would further training on ACDTs.

Personal protection training

35. Personal protection was a part of the Control and Restraint training that I underwent as part of my Initial Training Course (ITC). It took up a few hours on day 1 of the Control and Restraint 1-week training. This was in January 2009, and was refreshed yearly. I believe this was probably the best part of the training, was undertaken professionally and was in-depth.

Use of force

36. My Use Of Force training was week 5 of my initial 6-week training course and was held in February 2009. I have been refreshed yearly ever since. I believe this was probably the best part of the training, was undertaken professionally and in-depth.

The Role of a DCM

37. I have not been sent a copy of the job description (CJS004296) referred to by the Inquiry and would need to see a copy of the document before I can confirm whether it is an accurate reflection of the roles and responsibilities of a DCM at the relevant time.

38. I would have been a DCM during the whole of the relevant period as a Residential Manager. Back then you were assigned to a wing (mine was Bravo wing) and during the day I would manage A & B wings. Another Residential Manager would manage C and D wings. Everything on B wing would go through me. I was responsible for the day to day running of it - making sure staff were

doing what they were supposed to be doing and residents were happy and looked after. Oscar 1 deals with oversight of the entire building. They are DCMs on the same level as a Residential Manager but rather than being on the wing their role was more operational – making sure staff were where they were supposed to be, moving things around, incident management, key and radio checks, making sure no-one leaves the building, attending meetings with SMT that require input from anyone on the shop floor, absence management etc. The Oscar 2 is in charge of admissions and discharges and sits in the reception area with the new arrivals and staff, booking them in. They are also your back up if there is an incident as they will replay footage etc. In addition, if you have paperwork you can delegate some of it to them. They are responsible for checking paperwork on release and handling the cash.

39. I feel I engaged well with residents, I was open and honest with them at all times. I respected their situation and tried my hardest to help them as much as I could. Language could obviously be a barrier and was several times. During this period we made use of a company called 'Language Line' who provided translation over the phone. The service was okay but sometimes you would have to wait for a long while for certain languages. We would sometimes use other members of staff as interpreters if appropriate and for day to day enquiries we might use other residents but not for an ACDT or Home Office case related interpretation because of concerns about accuracy and confidentiality. These days we use a new service called 'big word' and this service is very good.

40. The only incentives for detainees were paid work opportunities. Detainees were able to undertake jobs such as cleaning, servery workers, barbers, gardeners, or gym orderlies. These roles would only be available if the detainee complied with the home office procedures and would be taken away for a month if the detainee was placed onto DC Rule 40 or 42. These opportunities would be managed by the paid work co-ordinator. Way back at the beginning of the contract one of the wings was an enhanced wing so if the detainees were well behaved or due to longevity they would be put onto that wing. This was later dispensed with. I'm not sure why. After that occasionally every couple of years there would be a cleanest wing competition the prize being a chicken dinner. It was successful but unfortunately that got dropped too.

41. The DCM role during ACDT reviews was to chair them and along with the rest of the board make a decision on what the action plan going forward was. This was adequate however I never received any training on this other than shadowing other DCMs.

42. The DCM role in an SLP (supported living plan) review would be to chair it and take advice from healthcare before making an action plan or decision going forward. We had no training on this either. Therefore, I would say this procedure and process was not adequate. Healthcare took the lead, however.

43. I believe there was a security policy underlining the strategy in preventing drugs entering the centre. There were searches for all visitors entering the building and there were occasional staff searches. Every 6 months or so there would be a full staff search. I believe we may have had the police dogs in twice when I was working on shift.

44. I wasn't directly involved in implementing the drugs prevention policy. There was a drugs problem at the time and therefore the measures in place were not fully effective. Spice had become a prominent drug. It was easy to get in. Every day 6, 7 or 8 times you would be called to an incident when someone was under the influence or needed medical help. It was a dark time and it was not nice to work there then. I don't recall any staff being caught bringing drugs into the centre or if staff ever did. I believe that drugs were much more likely to have been coming in through visitors.

    (a) These incidents were classed as a medical response which would be communicated to staff via the radios. My involvement during these incidents would vary depending on my role on any given day. For example, if I was Oscar ½ or a DCM on the wing where the incident took place, I would attend. My role could include any of the following:

        (i) Assessing the detainee for risk to himself and/or others;
        (ii) Ensuring that the detainee, other detainees and staff were safe;
        (iii) Contacting and liaising with healthcare;
        (iv) Attempting to de-escalate the incident;
        (v) Using force if necessary ie if the detainee was aggressive/threatening/ risk to himself;
        (vi) Placing the detainee in the recovery position and/or administering 1st aid;
        (vii) Ensuring that the wing was run as normal;
        (viii) Completing an incident report.

    (b) The steps that I took after such an incident would also vary depending on my role on the day, the nature of the incident and the outcome. It may involve ensuring staff completed the relevant paperwork promptly, open an SLP and/or ACDT if necessary, informing the Home Office and Deputy Director.

    (c) In respect of drugs being brought into the centre, I had no reason to suspect that staff would be involved. I simply did not believe that any of my colleagues would do such a thing. In addition to the seriousness of the offence (ie supplying drugs), I did not believe that any member of staff would bring drugs into the centre given the chaos that it causes such as negative behaviour, bullying, aggression and medical emergencies.

(d) More frequent searches and onsite drug dogs may have prevented some drugs from entering brook House.

Managerial Oversight

45. I don't recall any racist attitudes or behaviours amongst staff.

46. I don't recall any homophobic or misogynistic attitudes or behaviours amongst staff.

47. I don't recall any staff members bringing in drugs for detainee use.

48. I was never bullied by any staff at Brook House.

49. I don't recall any staff being bullied and was never given a complaint regarding this.

50. I am not personally aware of staff bringing drugs into Brook House, but I believe that a couple of staff may have been sacked for doing so.

Relationship with the home office

51. I feel I had a good relationship with the Home Office team, my level of contact with them would have been from a friendly chat to needing information from them about individuals for different reasons, ACDTs etc. My opinion is that they did their job well however they could maybe have been more readily available for detainee requests. For example, if a detainee wants to speak to HO they have to fill out a form requesting to be seen. Some urgent matters have a 3-day response time. Some queries could therefore not be resolved quickly enough. Every tiny bit of information the Home Office needs had to be written down and there was no fast track for urgent requests although you could probably go up yourself to the office and get more immediate attention. Now they are pretty good up there and you can go up and ask. Way back when it wasn't like that. It depended on who was working and how much they want to help. In the round however I think it was sufficiently balanced, aside for turnaround on requests. I don't feel able to make comment on any particular individual.

Relationship with senior managers

52. I had very little contact with the SMT when I was a DCO but more so when I became a DCM. My line manager would have had the most contact with me. Other than that, my level of contact with the others would mostly have been before during and after the daily morning meeting with them. My line manager was available mostly when I needed him, I cannot think of a time he wasn't. The daily Duty Director was available when needed, more often than not, unless they

were stuck in meetings. All together however the SMT weren't very visible to staff.

53. I had a good relationship and experience with my senior line manager, I had regular 121s and quarterly appraisals as well as a yearly development review. During the time period I believe my line manager would have been Christopher Milliken or Jules Williams.

54. Overall, however, the quality of leadership at the time was poor. It felt like you were doing everything on your own. Whilst we were working as a team together, we were operating on our own. There might be one manager running 2 wings. If a manager called in sick the remaining manager would be managing 4 wings. Whereas we might have expected help from people upstairs that was never there. We were left to ourselves quite a bit.

Relationship with junior staff

55. Coming from the role of a DCO I feel I was a good line manager to my staff helping them as I could. I conducted 121s regularly as well as the yearly development review helping them progress their careers. I was able to put my line staff on the courses they wished to attend or to give them the opportunity to shadow me as a manager to prepare them for a potential promotion.

Relationships with other DCMS

56. I felt more than able to rely on my fellow DCMs on my side of the shift, we worked well together and were able to assist each other when times got busy. At the time we worked with the same DCMS and there were 2 different shifts. This made it easier to rely on each other as we spent a lot of time together getting to know each other's weaknesses and strengths.

57. I was not aware of a management committee and cannot comment on this.

Relationship with healthcare staff

58. My experience of the healthcare team was mostly positive. They seemed short staffed a lot but did what they would with the staff they had.

59. In planned use of force incidents, they would always attend the briefing and be there on hand during the interventions and the following de-briefings. In spontaneous use of force incidents they were responsive to calls and attended the scene promptly. I was always satisfied with their participation and could safely rely upon them to monitor intervention and halt it if necessary. They have helped

me an untold amount of times over the years. Communication with them about individuals' medical needs was as open as it could be. Medical information would always be confidential however unless an immediate risk was posed to staff safety. Healthcare were always under a lot of pressure from detainees due to the situation they were in, but I cannot pin-point any bad attitudes by them.

Disciplinary and grievance process

60. During the relevant period and prior I had no involvement in any disciplinary investigations or grievances due to be fairly new DCM.

Staffing levels

61. Having 2 DCOs on a residential wing was never enough, there were simply too many daily jobs for 2 people to deal with on top of caring for detainees' general welfare. Having upwards of 100 detainees on a wing with 2 staff simply wasn't enough. It wasn't safe and it wasn't practical. This was raised several times but the reply would always be 'it's what the contract says. This would have been raised to several SMT members. More often than not staff would not get a lunch or dinner break during a 13-hour shift because of the lack of staff.

62. I was not alone in my concerns. Every member of staff would have raised this concern with different managers, it was a clear and obvious problem that we all knew about.

    (a) I specifically raised the shortage of staff and the lack of DCM's.on the unit

    (b) Because of the passage of time, I cannot recall specifically how, when and to whom I raised these concerns with. In general, such issues were raised verbally during the morning briefing and when movements were scheduled to take place. Often there was not enough staff to escort detainees across the unit hence raising the issue then.

63. I don't recall seeing a staffing plan in September 2017 and therefore cannot comment on this. I have been an employee through many different eras at Brook House before this date and after therefore I cannot recall this particular review of staff.

64. I believe detainees were always provided with the services and activities they were entitled to however this stretched the staff leaving other areas short. As a group I felt we tried our hardest to care for the individuals in our care.

65. The staffing levels majorly affected staff morale, sickness was high, and attrition rates were also high. It also made it very unsafe to work here. In my opinion 2 or 3 staff for up to 120 detainees is not safe.

66. Healthcare staffing would vary from day to day. Sometimes they appeared well-staffed and other times under-staffed. Healthcare saw as many detainees as they could during the allocated surgery times. Sometimes it would be hard to get a Healthcare member to the wing for any reason. They would always attend a first or medical response if anything happened on one of the wings.

67. I cannot fully recall the activities department structure for this period; however, it has never been sufficient until more recent times. During the relevant period it would be unusual to have more than 2 officers on each wing, though there could be up to 4. The courtyard was open all day and someone had to be positioned there. If there were 2 officers on duty the main focus had to be on the wing but the doors also had to be manned and there was some work to be done in the office, although most of this could be done on the night shift. Low staffing levels meant that not everything could be done as we were too thinly stretched.

Recruitment

68. I was never involved in staff recruitment at Brook House during the period.

69. Recruitment was never a problem as far as I was aware. People always need jobs, the salary was and is above the usual average wage and so attracted people to the job, however rarely anyone with experience was recruited.

70. I don't feel anything in the recruitment process would have improved retention rates.

Retention

71. Staff retention was always a problem as the shift pattern was not good, and the work home life balance wasn't ever taken into consideration. Others felt unsupported by line manages (not myself). A better shift pattern would have hugely improved retention. At the time in question we were working 13.5 hour shifts. We might maybe work 4 shifts and have one day off. There were too many days in the shift pattern.

72. The issues causing retention problems were the shift patterns and the shift times, the balance between work and home life, staff feeling unsupported, the lack of staffing on the wings, people finding better jobs outside. Mainly It was the DCOs who were leaving, the DCMs had a better shift pattern and the improved wage so there were less departures from this area. The above reasons are what I believe were the main reasons for leaving.

73. My opinion would be that in order to improve retention rates more staff need to be employed and there need to be better shift patterns to meet individual needs. An improved wage within all areas would also help.

Tinsley House Staff

74. The Tinsley House refurbishment benefited Brook House as it gave us extra staff for a short period of time. My opinion was that the Tinsley staff didn't want to work at Brook House as it was a more intense and tougher environment which they were not used to. They were not given any specific training as they had done the same initial course and were paid as a DCO just as the Brook DCOs were. Over time they did manage to adapt and some staff worked well and others didn't.

Treatment of detainees:

Individuals generally

75. I did not work on reception during this period and cannot comment on the arrival and departure process.

76. I did not work on the induction wing during this period and cannot comment on the departure policy.

Activities for individuals

77. I would say the lack of activities did lead to issues and disturbances, there wasn't an awful lot for the residents to do during the relevant period besides IT room, classroom, arts and crafts, gym and football/cricket. On the wing activities were majorly lacking and you could tell as the times where residents were locked on the wing there would be incidents more than when it was association time.

78. The period in question compared to now is hugely different. More activities are now available, there are better formats in the classroom with a wider variety, more sports are being carried out in the courtyards, one courtyard now has grass and gym equipment. More on wing activities are being used like for example bingo.

Immigration rule 35 process

79. The immigration rule 35 process, concerning detainees who were victims of torture, was essentially managed by Healthcare and the Home office. Healthcare dealt with this process, all we as DCMs did was refer residents who asked for this. All I knew was a doctor would have an appointment with the resident and I had no idea as to how long the process was. I have no knowledge of residents being refused an appointment.

Use of force

80. When I initially received the rule 9 request from the Inquiry on 15/06/21, I believed that I was a new DCM during the relevant period and, therefore, not directly involved in use of force as DCMs usually oversee the Control and Restraints but do not actively participate. In addition, I did not think that I led any during the relevant period. They would have been led by Oscar 1 and 2. At the time, I didn't think I had shadowed anyone so wouldn't have been confident to lead one. I started all the other DCMs were experienced so it never really came down to me. There was a lot of use of force during this period and I cannot remember any specifics. At the time, there was an immediate debrief following a use of force incident but I don't recall any further review of the force used, or any lessons learned exercise, although this may have taken place.

    (i) I have now reviewed CJS005540, CJS005543 and CJS005550 where I am listed as the person who authorised the use of force. In addition, CJS00540 (relating to force used on 9 May 2017) suggests that I was Oscar 1. I accept the same. I am not sure when I became an Oscar 1. The documentary evidence confirms that I did, in fact, authorise the use of force during the relevant period.

    (ii) The lead/supervising officer in charge at the scene of an incident was ordinarily Oscar 1, Oscar 2 or a DCM. The process was the same regardless of the officer's status. The lead officer would be responsible for many things, including: the initial negotiations and de-escalation; assembling sufficient staff; briefing the staff/team; further de-escalation; authorising the use of force and ensuring that the force was necessary, reasonable, proportionate and for no longer than necessary.

81. As mentioned above, DCM's ordinarily oversaw the use of control and restraint (C&R) as opposed to actively participating in them. The DCM would ensure that the C&R was undertaken correctly, efficiently and safely. In addition, the DCM led attempts at de-escalation and authorised the use of force during an incident that they oversaw. They would ensure that the force used was necessary, reasonable and proportionate in the circumstances and no more than necessary.

82. After a C&R, the DCM would ordinarily complete an Incident report and ensure that all the staff involved in the C&R completed the relevant use of force paperwork without delay.

83. There is no difference between an Oscar 1 or 2 leading a C&R, and a DCM overseeing a C&R.

84. If I had any concerns about an incident, I would have raised this at the time. I don't recall any concerns.

85. I don't have an opinion on the techniques being used as a mechanism to control behaviour. I don't believe they were used excessively at Brook House. Verbal

communication (de-escalation techniques) is the only real alternative and I believe that this was always used as a first response.

86. I have reviewed CJS005540, CJS005543 and CJS005550 where I am listed at the person who authorised the use of force.

(a) I do not recall these incidents and, therefore, I cannot add any further comment above and beyond that contained in above documents.

(i) CJS005540 relates to D2389. The detainee had escorted removal directions to Estonia on 9 May 2017. He was given many opportunities to walk to reception to meet the Over Seas escorts but he repeatedly refused. C&R was required as a last resort.

(ii) CJS005543 relates to D243 who was threatening to self-harm using a blade clenched in his fist. I attempted to de-escalate the incident to no avail. The detainee repeatedly refused to hand over the blade and, therefore, I authorised the use of force to remove it.

(iii) CSJ005550 relates to D1523. The detainee had refused many times to transfer to Morton Hall and stated that he would not do so under any circumstances. The detainee was given multiple opportunities to walk with me to discharge but he refused. I appear to have made all attempts to manage and de-escalate the incident without force and as a last resort C&R was used.

87. I have reviewed the transcript of the footage taken by DCO Callum Tulley on 17 May 2017 at TRN0000085. On page 4, line 122, I appear to have told the detainee that "*the reason we've used force on you, you've given us no good reason to – you said for the past week and a bit you refused to go and you told me I had to [inaudible] you out. You didn't want to do it*".

(a) I cannot recall this conversation, nor the incident. However, I do not accept the suggestion that there was no prior communication with this detainee, including de-escalation techniques.

(b) Although I cannot recall this incident, I am confident that I would have further communicated and used de-escalation techniques immediately prior to the use of force. I am confident that I would have exhausted all reasonable attempts to manage and de-escalate the incident.

88. I have reviewed CJS005620, in relation to the use of force against a detainee on 22 May 2017. I have also viewed the footage UOF129.17 BWC which I understand is the footage from DCM Brackenridge's body worn camera during the incident.

(a) I cannot recall this incident but I am assisted by the footage and documents. I was the supervising officer in charge of the scene of the incident. Prior to the incident, the detainee had directed threats to the Home office regarding his removal direction on 23 May 2017. A decision was made to move the detainee to Eden wing in preparation of his removal the following day. He stated that, under no circumstances, would he leave the UK and that he would cause problems for the Home office. I asked officers, including Joseph Marshall, Ben Wright and Derek Murphy to accompany me to a visits interview room to speak to the detainee. I assembled sufficient staff to manage the situation. We entered the room and I sat directly opposite the detainee. I attempted to de-escalate the incident and explain the situation to him. I attempted to explain the rationale for moving him to Eden Wing to no avail. I told the detainee that he would still have full access to all the facilities he required to maintain contact with his solicitor. I attempted to explain the position to the detainee for several minutes. I made all reasonable efforts for a peaceful resolution.

(b) The Inquiry has queried how instructions are given to commence use of force techniques. I am not aware of any specific way and/or term that is used when commencing C&R. Sometimes, detainees will be told verbally that the use of force will be applied. On other occasions, depending on the detainee's behaviour, the lead officer may motion for other officers to commence the use of force.

(c) The footage shows that I engaged the detainee for several minutes. I attempted to de-escalate the incident by explaining the situation to the detainee and reassuring him that, for example, he would still have full access to all the facilities he required to maintain contact with his solicitor.

(d) Given the detainees earlier threats, I attended upon the detainee with sufficient staff to manage the situation. I made all reasonable attempts to de-escalate the incident. Unfortuantely the detainee became more agitated which, as a last resort, necessitated the use of force. Handcuffs were applied and restraints removed once the detainee was under control. I have had the opportunity to review INQ000111_87 to INQ000111_90, namely the report of Jon Collier. In hindsight, I accept that there was time to prepare and plan as a planned removal.

(e) I do not recall this incident and, therefore, cannot comment on the reason why control of the detainee's legs was necessary. The footage shows that it was a difficult restraint with a resistant detainee in a confined space.

(f) I consider that the use of force was necessary, reasonable and proportionate in the circumstances.

(g) I was concerned about the safety of my colleagues during this incident. I did not hear the inappropriate and unprofessional conversation between my colleagues as referred to at INQ000111_089.

89. At CJS005620, I reported the injury of D52 following the use of force on 22 May 2017 as '*small cut to toe*'.

(a) I was most likely informed of the injury to D52's toe by Healthcare.

90. I have reviewed CJS001582, CJS005591, CJS001466 and CJS001449 relating to an allegation of excessive use of force against D2054 on 28 June 2017.

(a) Pages 9 to 12 of CJS00591 contains an accurate summary of the evidence that I gave to the Professional Standards Unit.

(b) At page 12, it is said that all the officers, and therefore including me, commented that had D2054 banged his head, been unconscious or bleeding, healthcare would have stopped the removal. If I believed that there was a medical emergency and/or healthcare concerns, I would suspend the removal and seek the views of Healthcare.

(c) The Inquiry has queried whether, in hindsight, I would have done anything differently in this incident. I have had the opportunity of considering INQ000111_0074 to INQ000111_79, namely the expert report of Jon Collier. In hindsight, I accept that; (i) once control had ben gained, the helmets and gloves could have been removed; (ii) the head support could have been removed; and (iii) the practice of handcuffing in the seated position should be withdrawn. Although none of the above recommendations were part of the C&R training and were not practiced at the time, I accept that they may assist with de-escalation.

Individual Welfare

91. I didn't have any training in mental health.

92. We have the ACDT process to help manage people's mental health when it is at its worst. An ACDT is opened if someone has self-harmed – it is a care plan to support them through the crisis period look at their needs and how you can support them. It is documented in a booklet and you tick off when steps have been completed etc. For example, an ACDT would be opened if a detainee showed signs of self-harming. Anyone can open an ACDT – Healthcare, DCOs, DCMs, Chaplaincy, and the Samaritans. Once opened, residents get assessed by an assessor – normally a DCO. The plan is reviewed daily or whenever needed by a multi-disciplinary team usually chaired by a DCM but involving Healthcare,

a mental health worker, the Home Office,chaplaincy and a Duty Director. As many people were involved in the review as possible to justify the decisions made at the end. The ACDT was also conducted and reviewed with the input of the detainee in question. A detainee does have the opportunity to voice any disagreement at the review. However sometimes the detainee would not be in agreement but would still have to go along with it if deemed to be in their best interests – an example of this might be being placed under 24 hour watch. A detainee might not necessarily agree with the level of observation but due to the possible risk and the environment the recommended level of observation would have to be imposed. Sometimes the detainees don't engage in the process, so we do it without them. However, we try to take them along with the process as much as possible and normally they want the help.

93. I don't really recall the healthcare department's way of dealing with mental health other than they had a mental health nurse.

94. Drugs were a problem during this time. Several residents would be under the influence of drugs which made working on the wings hard due to people over-dosing or using bad drugs. It made other residents upset and worried as they never knew what to expect on a daily basis or if someone would get hurt because of drugs. I don't believe there was a good enough policy to deal with drugs being bought into the centre at the time as there was an issue with drugs but this isn't my area of expertise to make a meaningful comment on it.

95. I can't recall if we had on site drug support at this time. Healthcare did provide support but to what extent I cannot remember.

96. The chaplaincy was made up of several different religious ministers, they never raised any concerns regarding welfare with me.

97. If a resident self-harmed the ACDT process would be followed. I believe this process is and was effective in supporting residents.

98. The way we manage food and fluid refusals has changed several times over the years therefore I cannot remember what the process was at the time in question.

Individuals as time served foreign national offenders (TSFNO)

99. I did not work in reception at this time and therefore cannot comment on this process. TSFNO residents were sometimes more challenging than non TSFNO residents however my approach to them never changed, and was not influenced by this. However, if any issues or situations arose on the wings it would generally be involving a TSFNO.

100. The only other difficulty with mixing TSFNOs on the wings would be when we had residents who had never been to prison becoming anxious and worried about

who they would be sharing a room with or who they would be located around. This could be intimidating for non TSFNOs.

Abuse of individuals.

101. I never witnessed any situation which made me have cause for concern of physical or verbal abuse. If I had any concerns of abuse physical or verbal by staff or others, I would have raised these concerns with SMT however I don't recall any such incidents.

102. I saw general fights and altercations between individuals on a daily basis. I wouldn't call it abuse though. It was mainly residents going at each other. If they did come to us to say they were being abused we had an anti-bullying log and we would open up a document and monitor the individual or perpetrator. I can't remember if that process was in place or not during the relevant period.

Complaints

103. At the time, I didn't have any understanding of the complaints process other than that detainees filled out a complaint form and it was then handed to a manager to look into within 14 days.

104. I don't recall any times where I had to complete a complaint and refer it for investigation or any times that I was involved in an investigation aside from PSU investigations. I was involved in these as a witness on several occasions, which is not unusual, particularly at the time. They tend to be conducted in relation to use of force incident. PSU investigations are less common now in my experience and I can't recall the last time that there was one/

105. I can't remember the detail of the system at the time for complaints as it has changed several times over the years.

106. I believe that the same form was completed by residents if it was a complaint against healthcare.

107. I am not best placed to comment on whether the complaints process could be improved, but I don't think so really.

Specific question raised by the Inquiry in their letter dated 10 March 2022

108. I have reviewed CJS005880_2. I note that this document refers to 'Dave'.

(a) I cannot recall this incident and, therefore, I cannot confirm whether I am 'Dave' referred to by D119. I understand that there were many members of staff called Dave during the relevant period.

(b) Given that I do not recall this incident, I cannot confirm whether D119's recollection is accurate and/or describe any further involvement in this incident.

(c) If I was told that an officer had provoked a detainee, I would start an investigation. I would speak to the detainee, the officer and any potential witness. In addition, I would consider submitting a Security Information Report. The outcome of the investigation would then dictate the next steps.

109. I have reviewed CJS001979_1 which relates to a planned move for D71. I cannot recall this incident.

(a) If a detainee told me that he was unwell and too sick to travel, I would inform Healthcare.

(b) I cannot recall this incident and, therefore, I do not know whether I contacted healthcare on this occasion. However, I would ordinarily contact healthcare in these circumstances.

(c) Please see my response above.

110. I have reviewed HOM002573_2; HOM002544; HOM002748; HOM15608 and HOM002187 in respect of D668.

(a) I do not recall this incident. I note that I provided a statement on 29/01/18 (HOM015608). I did not recall the incident then nor do I now.

(i) I do not recall this incident and, therefore, I cannot confirm what steps, if any, I took. (ii) If I was told that a detainee did not feel safe and had concerns over spice in the centre, I would first speak to the detainee and ascertain further information. Their response would dictate the next steps.

(b) The investigation found at paragraph 8.4 of HOM002748_44 that I did not follow the complaints process and did not document the incidents on Security Information Reports (SIRs) or Information Reports (IRs), or retain the CCTV footage as I should have done. The Inquiry has queried whether I consider the above to be a reasonable conclusion. It appears that the investigation concluded that DCO Avery raised these concerns with me. If that is what the investigation found, then their conclusion was reasonable based on their findings. However, I do not recall the incident and, therefore, I cannot confirm whether DCO Avery did, in fact, raise these concerns with me.

111. I have reviewed CJS001033_2 in respect of D1914. According to this document, D1914 went on an emergency escort on 18 April 2017.

(a) If a detainee was required to stay in hospital overnight, their emergency escort status was changed to bed watch.

(b) The decision to change a detainee's status from emergency escort to bed watch was automatic in the circumstances described above. It did not require a multidisciplinary approach, nor did it require a decision from any particular member of staff.

(c) A change in status as described above may be recorded in the detainees ACDT but I am not aware of a mandatory requirement to do so. An ACDT would not automatically be opened simply because a detainee's status was changed from emergency escort to bed watch.

Assessment, care in Detention and Teamwork plans (ACDT's):

112. I have reviewed HOM006151_3 and CJS002964. I do not recall these cases. The documents do not confirm that I closed the ACDT.

(a) In relation to D1440 (HOM006151_3), the detainee detention history document, states that the Home Office had received IS91RA Part C from me and; '*ACDT closed due to no further threats or thoughts of self-harm'*. Without reviewing the ACDT document, I cannot confirm whether I did, in fact, close the ACDT. I could have been completing the Part C for a colleague to shorten their work load.

(b) In relation to D1373 (CJS002964), on 4 August 2017, I completed Part C; Supplementary Information to IS.91RA. I stated that '*D1373 has had his ACDT closed due to having no current thoughts of self-harm or suicide'*. Without reviewing the ACDT document, I cannot confirm whether I did, in fact, close the ACDT. I could have been completing the Part C for a colleague to shorten their work load.

(c) The decision to close an ACDT was multidisciplinary. The decision was made at the detainee's case review and involved input from many professionals including healthcare, RMN, residential staff and DCM's

(d) Ordinarily, an ACDT would not be closed unless there was agreement from all those who attended the case review. A post closure interview would also be held between a DCM and the detainee.

113. I have reviewed CJS001107 and DL0000187, both relating to 17 April 2017 where it states that I attended an emergency case review for D1527.

(a) I do not recall this incident and, therefore, I cannot confirm what steps I took to secure D1527 an appointment with a Doctor or otherwise follow up. Ordinarily, I would ask healthcare to arrange the appointment.

(b) As mentioned above, I do not recall this incident. Although detainees are prescribed medication, it is their choice whether to take it. Ordinarily, if a

detainee told me that he had not taken his medication, I would pass this information to healthcare.

Removal of Association (rule 40)

114. I have reviewed CJS0073132 and note that Stephen Skitt recorded that I was unaware of an assault by D476 on DCO Avery and, that if I had been aware, I would have authorised the removal of association for D476. I note the apparent inconsistency with what I said in interview (CJS001601_13).

(a) I cannot recall this incident and, therefore, I cannot confirm the point at which I became aware of the incident nor whether I considered the removal of association for D476.

115. I have reviewed TRN0000095 at pages 63 to 64, which is a transcript created from footage recorded by DCO Callum Tulley on 13 May 2017.

(a) I do not recall this incident and, therefore, I cannot confirm whether the nurse who stated, '*David, can you get the oxygen in'* was referring to me. I am usually referred to as 'Dave' and not 'David'. In addition, I would not be required to use healthcare equipment and, therefore, I suspect that this was not me.

(b) (i) I do not recall this incident and, therefore, I cannot confirm whether Derek Murphy, who stated, '*David, right, we are going to search his room as well',* was referring to me.

(ii) If a detainee was suspected of being under the influence of drugs, staff would conduct a brief search of their room to ascertain whether the detainee was in possession of any drugs. If so, staff removed the same. I do not recall this incident and, therefore, I cannot confirm whether any of the lines titled '*male staff*' or '*male manager'* was me.

Food and Fluid Refusals

116. I have reviewed the food refusals forms which I completed in relation to D1527, namely HOM032224_1 and DL000188.

(a) I ascertained the cause of a detainee's food/fluid refusal by asking residential staff on the wing.

(b) I do not recall this incident and, therefore except for inputting the information onto the above documents, I cannot confirm what I did, if anything, in response to D1527 remarking that he was stressed. Ordinarily, if I was told that a detainee was stressed, I would instruct the residential staff or DOM to speak to the detainee and obtain further information

117. I have reviewed HOM000517_02. This document states that, on 24 April 2017, '*Andy Lydon and Dave Aldis repeatedly spoke to D1527, de-escalating the situation, requesting him to move to go to E wing'.*

(a) Andy Lydon was Oscar 1 on the above date. He would have taken the lead in respect of de-escalation. I do not recall this incident and, therefore, I cannot comment on what I did or did not do. Ordinarily, de-escalation involves speaking to the detainee, ascertaining the reason(s) why they were behaving in a particular way and explaining the situation to them.

(b) I have reviewed the Eden Wing Initial Assessment for this incident at HOM003004.

(i) Except for possibly informing DCM Povey that the detainee was being moved wings and the reasons why, I would have had no further input into completing this assessment.

(ii) The Eden Wing Initial Assessment form was ordinarily completed by the DCM on E-wing hence the reason why I did not complete it.

(iii) I do not recall this incident and I did not complete the Eden Wing Initial Assessment form. I cannot, therefore, comment on whether healthcare was consulted save to say that they ordinarily would be.

(iv) During the relevant period, detainees subject to high level observations were placed on E-wing hence the reason why D1527 was placed on E-wing.

(v) The Inquiry has asked whether section 2 on the Eden Wing Initial Assessment form was completed prior to any movement to E-wing. I did not complete the form and, therefore, I do not know.

Tascor

118. I have reviewed CJS005891, which includes a report by me regarding a use of force by Tascor officers in an attempt to remove D1738 on 9 May 2017.

(a) I do not recall this incident and, therefore, I cannot confirm whether any searches were undertaken to ensure that D1738 did not have any items on him to cause himself or others harm. However, unless a full search had been authorised and/or requested, detainees were not searched before being producing to escorts. They were, however, searched by the escorts.

(b) I do not recall the incident and, therefore, I cannot explain what made me think that the use of handcuffs was being used as pain compliance save to say that I often observed Tascor using handcuffs for such a purpose.

(c) The Inquiry has queried whether there was anything I could have done to prevent or mitigate the usage of pain compliance by Tascor on D1738. I do

not recall the incident and, therefore, I cannot comment. Once a detainee is handed over and in the custody of Tascor, our authority ends. However, if I witnessed Tascor using excessive and/or inappropriate use of force, I would immediately intervene and report them.

119. I have reviewed HOM002758 which is the PSU investigation into an incident with D1738. I do not recall the incident and, therefore, I cannot comment as to whether the force was reasonable, proportionate and necessary.

The Panorama Programme

120. I am aware of the Panorama programme and I watched it the day it was released. I have not watched it since. I watched it at home. It was terrible but is more disturbing to those not used to the environment. It highlighted some serious concerns, but I never saw any of the behaviours that were shown in the programme. The environment as depicted in the programme looked much worse than it was generally in reality. The scenes captured came as a shock to me.

121. I worked at Brook House at the same time as reporter Callum Tulley but I didn't really work alongside him. I think he was an activities officer. I knew who he was rather than knew him.

122. I did not appear in the programme.

123. Staff felt let down by the colleagues who were shown in the programme behaving badly leading to low morale.

124. If someone makes a claim that they are under-age then the Duty Director is to be informed immediately and then a care plan is put in place for them. I'm not sure if this was the case then but it is now.

125. There were several changes made after the programme however due to the time frame I cannot remember everything that was changed.

Specific Individuals

126. I cannot comment directly on the Inquiries assertion that listed individuals were investigated, disciplined, dismissed or left following Panorama but in response to the Inquiry's request I comment as follows:

a) Nathan Ring; was a DCM on my shift, he was good at his job hard working. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.
b) Steve Webb was a DCM on the other side of the shift, so I never worked with him.

c) Chris Donnelly was a DCM on the other side of the shift, so I never worked with him.
d) Kalvin Sanders was a DCO who wasn't working at Brook House long before the programme was aired. I can't really have an opinion as I hardly worked with him however, I don't recall witnessing any abuse of concerns for his behaviour.
e) Derek Murphy was a DCO on E wing, very hard working, extremely helpful to residents, caring and honest. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.
f) John Connolly was a DCO who mainly worked at Tinsley House. He was a Control and Restraint instructor and I believe he may have completed one or two of my refresher courses. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.
g) Dave Webb was a DCO on E wing. He was a good officer, very helpful, and put in a lot of effort. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.
h) Clayton Fraser was another Tinsley House DCO. I can't recall ever working with him.
i) Charles Francis was another E wing officer. He was helpful and very caring. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.
j) Aaron Stokes - I don't recall this officer.
k) Mark Earl- I don't recall this officer.
l) Slim Bessoud is a DCO. He is helpful and good for translation. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.
m) Sean Sayers was a DCO who I believe was on the other shift so I wouldn't have worked with him.
n) Ryan Bromley is a DCO. He is a hard worker, did what was asked of him, and was good with residents. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.
o) Daniel Small was a DCO I didn't work with him enough to have an opinion on him. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.
p) Yan Pashali was a DCO who I didn't work with much, I remember him being hard working, helpful and caring. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.

q) Daniel Lake was a DC. I didn't work with him enough to have an opinion on him. I didn't witness any abuse from him. I don't recall having concerns for his personal views or behaviours or recall hearing him make any derogatory or offensive remarks.
r) Babatunde FAGBO was an DCO I had worked with him for a few years. He was hard working, good at his job and was good at engaging with residents, he spoke a few African languages, so this helped quite a bit. He would help residents when needed. I believe he became a seconded DCM at some point.
s) Shayne Munro was a DCO on the other shift, so I didn't work with her.
t) Jo Buss was a nurse, I didn't witness any abuse from her. I don't recall having concerns for her personal views or behaviours or recall hearing her make any derogatory or offensive remarks.

Suggestions for improvement

127. I believe in the time since the programme a lot has already changed and conditions for residents is much better, they have more access to the things they require and have many more activities on offer to them. Staff wise there needs to be a better shift pattern for them to work. Home/work life balance is poor which leads to low morale.

Any other concerns

128. I have no other matters which are relevant to the Inquiry.

129. Making a list of names of people who would be knowledgeable about the matters mentioned in the statement would be impossible. I've worked at Brook House for 11 years no way can I make a list with the number of staff I've worked with.

130. There are no other matters relevant to the Inquiry as far as I am aware.

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	Dave Aldis	
Signature	Signature	
Date	23/03/2022	