BROOK HOUSE INQUIRY

First Witness Statement of Slim Bessaoud

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 5 July 2021 and a further request date 15 October 2021.

I Slim Bessaoud, date of birth DPA will say as follows:

Introduction

1. Prior to my role at Brook House I was an agency worker and worked in warehouses, in hospitality and on building sites. My first permanent job was with Evans Cycles in 2009 following which I joined Brook House. Although my contract says that I am employed to work at both Tinsley House and Brook House I have always worked at Brook House and have only been to Tinsley House a couple of times.

Evidence

2. I started working at Brook House IRC as an Assistant Custody Officer (ACO) on 14 February 2011. I had initially applied to be a DCO (Detainee Custody Officer) but my application was late and they offered me an ACO position. When the opportunity arose I applied for the role of a DCO.

3. My role mainly involved administrative duties with no detainee contact. I was positioned mainly in the visitor's centre where I would log the visitors (both legal and social) and accept property and cash for the residents. I would also book visitors in for any future visits and worked in the satellite gate searching visitors, accepting and delivering post, monitoring CCTV, and making Home Office appointments.

4. In October 2014 I completed the training to become a DCO and I was placed in the control and security and then the visits department. As a DCO I worked with residents on the wings and in visits and activities. Over time, I worked in every department apart from reception. In that role I looked after detainee welfare, checked emails from the Home Office, made sure that detainees attended meetings with the Home Office

SLIM BESSAOUD 03/02/2022 Signature

etc. Most of the time I worked as a November 1 (collecting residents for their Home Office Appointments, legal or social visits). November 1 is a radio call sign and that person is now based in the visits department and in charge of paperwork for the day, responsible for arranging meetings between the residents and Home Office and making sure that everything runs smoothly in the visits corridor.

5. During the relevant period the main function of November 1 was to facilitate appointments with the Home Office. November 1 would also patrol or carry out security checks, area searches or relieve people for short breaks.

6. Sometimes I would be rostered as a Tango in which case I would be in charge of the visits department for the day making sure that all residents arrived for their appointments on time. As a Tango 3 or 4 I would assist with searches of detainees as they attended their appointments and if I was rostered as a Tango 5 or 6 I would work in the visits hall showing visitors to their table, patrolling the hall and using CCTV. On other occasions I would cover the wings and activities. Currently I still work at Brook House IRC as a DCO in the visits department employed by Serco, who took over the contract from G4S in 2020.

7. As a DCO, the duties also included preparing a list for the next day, releasing the workers, ensuring the wings were clean and patrolling the wings every other hour. The patrols were recorded in the diary.

Application Process

8. I applied for the role as DCO because I thought that I could do the job. I am a caring person. I felt that the job was for me. I saw it advertised on the website. I spent a lot of time as an ACO and there was a lot of communication between ACOs and DCOs. I therefore had a rough idea about the role of the DCO before I applied for it. I had an interview with one of the managers and also had to do a test, following which I was offered the job.

9. In my opinion the recruitment process was adequate. I feel lucky as I was able to view other officers perform their duties when I was an ACO.

Culture

10. I was not aware of a specific culture at the time. I worked in the visits department and had a great team that were supportive and understanding. The nature of the visits department requires more patience, flexibility and understanding because of the potential for the Home Office to make decisions that would deprive the resident of their liberty or deport them to their original country. I used to cover the hall where they could get closer to their family or friends. It felt more friendly as they had a children's corner where they had toys for the children, colouring books and crayons. All other departments that I worked in occasionally also had supportive staff, despite the staff shortages.

11. The atmosphere could be severe at times. Brook House at the time could feel like a prison. There were issues with drugs and the required level of security was higher than it is now. It felt watchful. We were watching out for every single movement. It was not a quiet relaxed environment. Things have changed for the better as it is now more relaxed and welcoming. There is more understanding, for example when visitors bring their children with them on a visit etc. At that time drugs were coming into the Centre and there were a lot of issues on the wings related to that.

12. Staff morale was low but everyone was trying to do their best to support each other. Staff had long shifts and a high workload. There was a lack of support from managers and SMTs. The shifts were 13.5 hours long. I don't actually remember the increase, but we all did 7.45am to 9.15pm. If there was an incident we had to stay behind. Our shift pattern was 3 on 1 off, 3 on 1 off, 2 on 2 off. It was a difficult time. However, I did not personally experience any unprofessional attitudes. Everyone was professional.

13. There were staff shortages because morale was low. Due to the staff shortages, long shifts and the workload, people would go off sick and for stress. Loads of people went off for stress or stepped down to ACO level. People were tired. Staff would also leave. At the time a lot of people were leaving. Some couldn't cope with the pressure and stress.

14. In my department even if no one was sick there was not enough staff. I think there was about 4 people on the shift. The morning shift was ok but when the social visits

started and November 4 and 5 had to go to the visit hall, the corridor was left short. We had legal visits, surgery, welfare groups and other visitors. It was hectic. There were not enough staff on the day. There would be November 1 plus 4.

15. Tango 1 would be in the office arranging paperwork. Tango 2 and 3 would be doing searches, updating the visits board and identifying people coming in for interviews. November 4 and 5 would help out in the morning with the list and later would start social visits. Sometimes we would have two or three lists from the Home Office and they would keep updating the list so November 1 would have to go and find the additional people, Tango 1 would have to arrange the paperwork and November 2 would have to do the searching. In one list you might have 10 detainees and between each interview you would have 5 or 10 minutes. We had to find the residents and present them to the Home Office on time to avoid penalties.

16. There was also a shortage of officers as well as staff generally. There were usually 2 to 3 officers on duty on a wing during the day shift and 1 officer per wing on the night shift however, there should have been a minimum of 3 officers on day shift. There is only so much 2 or 3 people can do to control a situation. If things escalated and de-escalation was not working we would have to resort to use of force. This would require 3 officers and following an incident the officers would have to write their use of force reports. This put pressure on the staff and in my view raised safety issues.

17. From what I saw, these pressures did not affect the attitude of staff to residents and staff remained professional and polite. I never heard anyone complain about the treatment of residents and never witnessed any inappropriate behaviour. I had no contact with the SMT. If I had an issue I would go to an Oscar 1 or 2. If I had concerns about a resident for example if they were on an ACDT or if they had received bad news from the Home Office I would make DCOs and DCMs aware. If you wanted to see an SMT member you had to go to their office. It was rare to see a senior manager. Often I did not know who my line manager was.

18. The lower level management DCM (Detainee Custody Managers) were in my view trying their best. Unfortunately, the SMT (Senior Management Team) appeared to be distant and unwilling to resolve issues or offer support to others. At the time there was a lot happening but I never saw a senior officer come onto the floor to show support.It

felt like we had been left to resolve these problems ourselves. In my view everyone felt a little abandoned by senior management. It felt like they were detached from us. Things have significantly improved now. The way we communicate now is so much better. Simple things like emails and on-line training and availability of computers to all staff who have our own log ins has been transformative.

Social Visits

19. In the morning, there would be four officers allocated to work in the visit hall.

20. Oscar 1 was provided with a report from the security manager, which would be reported down to us. The security manager would go through a list of the visitors' book and carry out risk assessments relating to drug passes, violence and gangs.

21. From the report, we could create a plan of the tables and place detainees and their visitors appropriately. For example, we separated the families and put them next to the toy area. If someone was a risk to women and children then we would place them further away and if someone was identified as a risk for drugs then we would place them nearer to the desk so we could keep a close eye on what was going on.

22. Detainees were allowed up to three adults visiting during a session and there was no limit on children so it could get quite crowded.

23. After lunch, the social visit started at 2pm except for Friday's when they started at 2.30pm. Two officers would go into the visit hall during the afternoon visit. One officer would sit at the desk in the visit hall and one would patrol. The patrol would be recorded in the diary. As well as patrolling the hall, there were three sets of monitors. Two of the monitors had four cameras but there was one which could not be moved.

24. Another social visit session took place between 6.30pm and 9pm, which was at the end of the day shift.

25. During the relevant period, the visit hall would get really busy, almost 90% of the visit hall would be full. We had 15 tables and almost all of them would be booked every session.

26. At the time there was not enough staff in the visit hall and there was a lot of problems going on with drugs which meant there was a lot of restrictions such as no physical contact, children could not run around and visitors could not pass on documents.

27. I do not recall receiving any specific training to work in the visits hall but since then they have introduced shadowing training to enable staff to learn on the job from colleagues.

28. A company called Forward Trust was also introduced to provide support in relation to drug awareness however there was no specific training on psychoactive substances provided to staff.

29. In my opinion, ahead of visits, visitors should be given a document about visiting policies so they have time to read it properly and are more likely to take notice. At the time, it was usually switchboard who arranged visits.

Physical Layout of Brook House

30. I am familiar with the layout of Brook House. I have no concerns about the layout of the building. The way in which it is set out means that residents can access all the facilities. I believe that Brook House is set out the best it can be for residents to access all services.

31. I have heard it described as being like a prison many times by residents. The lock up during lunch, evening and night-time perhaps gives it that feel as does the system but it has to be secure. Serveries, courtyards and activities are all accessible by residents and I try to reassure them that they are not in a prison but in a Home Office building. Perhaps the only concern I had at the time was the lack of fresh air in the rooms. Sometimes the air conditioning doesn't work as effectively as it might.

32. E-wing has two rooms that are used for medical purposes, two rooms for residents requiring constant watch and other rooms that are used after the de-escalation following rule 40 segregation, for residents who pose a security and intelligence risk, residents who are vulnerable, or those who had been served with a removal order, particularly those who were not happy to go or where there is a complex removal (e.g. they had refused to go previously).The atmosphere could be aggressive, emotional

and highly charged due to the nature of the issues being experienced by the residents on that wing. It could be intense. Anything could happen at any time – self harming, a fight, aggression. Once on E-wing, residents get better attention as there is a greater officer to resident ratio and that allows for better individual surveillance. There are only 13 rooms whereas there would be 120 detainees on an ordinary wing.

33. At the time there was always someone on E-wing. We had a lot of cases with people with mental health issues or who had self-harmed or were at risk of self-harming. It was manned by DCOs and DCMs. Sometimes it was necessary to deploy staff from other wings to man E-wing for example perhaps when a high-risk resident needed more staff on the wing. I worked on E-wing on a few occasions on the night shift.

34. For the residents to go back onto their normal wings their behaviour had to improve dramatically. I believe that prior to a resident being transferred out of E-wing and back onto one of the other wings there would be a review by the SMT of mental health issues etc and a risk assessment would be done.

Policies and Procedures

35. At the start of our training we focused on policies and procedures and DSOs. Copies of some of the procedures were contained in folders that we could access. There are a lot of procedures in Visits and whilst I do not recall being told to read any specific policies, I always tried to find the right policies and made sure I understood them. It required some personal effort. I relied a lot upon observation and on the job learning and I found colleagues to be very supportive in this. The necessary procedures were followed by all staff in Visits and were helpful. A simple example would be a visitor turns up to the visitor centre. He gets checked in and has to be searched. The procedure is a Level B search so once the visitor arrives he is logged in and checked to see whether he has money etc. as he is not allowed to bring it in. We have vending machines outside for drinks and refreshments. Any money left has to go into a locker. When he comes in, he has no physical contact so that nothing can be passed onto the residents. I believe that that procedure was written down but nobody taught me the procedure, I just got on with it and learnt it on the job.

36. G4S would carry out audits and updates but I cannot comment on this further as my recollection is vague and I was not involved in this process.

Training

37. As an ACO in 2011 I underwent a 2-week training programme in which I was trained in searching both visitors and residents to include vehicles. I learnt about relevant policies, personal protection, health and safety, first aid, security reports and policies, communication, the control room and CCTV. As a DCO in October 2014 I received 7 weeks of training which covered the above and also control and restraint techniques, escort training, use of force and scenarios. The use of force training was very good and included personal protection training for when you find yourself on your own or are being attacked. Its purpose is to enable you to defend yourself if you are facing danger or think you are in danger and there is no one else there to support you. You do what it takes to protect yourself. Control & restraint is divided into 2 parts – planned and spontaneous.

38. We received annual refreshers in areas such as control and restraint, health and safety, security, equality and diversity. We were trained in personal protection and received refreshers. I was happy with it.

39. We had no specific training for activities that I can recall.

40. As an ACO I had already developed a fair idea of what to expect. I found the training for the DCO role to be useful but nothing prepares you for the real thing. I believe that now prospective recruits may be taken inside to get a feel for the environment. I did not have that chance unfortunately and I did not know what to expect. At the time it was very hard to know what to expect and whilst the training was very intense the reality when I went onto the wings and faced the issues there it was not what I had been prepared for.

41. At the time we had no mental health training. This has been introduced lately. There was a fair amount of stress in the role. Many staff left or stepped back into ACO positions because of the stress. In addition, the residents we were looking after were also often stressed. Being in this environment, locked up behind doors is stressful. The training we now have focuses on managing residents with mental health issues and covers general areas such as identifying stress and mental health issues in both staff and residents. Training is therefore helpful.

42. Back in 2017 if I was concerned about any mental health issues I would report it but at the time because we were short staffed with 2 or 3 officers looking after 120 residents it was not easy to identify problems with individuals until there was an incident. I am now better informed and better able to identify something earlier if I come across it. Prior to the training I had no real idea how to identify mental health issues.

The Role of a DCO and relationships with detained persons

43. I have not been provided with a copy of the DCO job description referred to by the Inquiry solicitor so am not able to comment specifically upon it.

44. I have a very relaxed approach to residents. I am multi-lingual having come from Tunisia in 2006 and I speak French and Arabic and a bit of German and Italian. I speak mainly French and Arabic with the residents. Sometimes however there will be a resident who doesn't speak French Arabic or English and language barriers will always be a challenge. At the time we had the translation service BigWord to assist us and sometimes we could use other members of staff for translation support.

45. There was no reward scheme that I was aware of. As far as I recall everyone had the same privileges unless they were on rule 40 or 42. We would use de-escalation techniques where appropriate to manage residents' behaviour and there were some rewards in activities – competitions – for example winner might get a trophy. Activities were helpful in maintaining calm.

46. The ACDT process is essentially a care map for vulnerable residents (for example someone with low mood/depression or who is perceived to be at risk of self-harm, or who has self-harmed, or someone who has been served with a removal direction). The plan differs from one individual to another but when an issue is identified the person who has identified the issue has to open an ACDT and say why it has been opened and forward it to the manager. After that that person or resident has to be assessed within 24 hours and they are observed until assessment. The managers will inform the Home Office, Healthcare and the Chaplaincy etc. That person will then be looked after and placed under observation. The visits corridor is probably the most sensitive part of the building where people get bad news and therefore I have to be particularly alert to issues. Sometimes residents talk and sometimes they don't, and not talking can be

a sign that all is not well. You have to be able to read behaviour and pick up on that as well as speech. That is why we have the mental health training now. It has opened my eyes on many things I did not know before about how people behave.

47. There were some issues with drugs at Brook House at the time. Drugs got into the centre and we did not know how. There were so many ways to get drugs in and those doing it are very clever. Drugs can come in through visitors and on a few occasions, we found concealed items in the visit hall. Visitors would use different ways to hide it, even internally, smuggling it in using their babies. Visitors would be searched when they entered the centre and when they came out of the toilet. However, we could only use the wand on babies and children and that will not detect drugs. Residents would also be searched when they left the visit room. However, drugs might also come in through the post or in packages. These would be x-rayed and that was quite effective. However, Spice could be sprayed onto paper. There were a lot of drugs around and a lot of detainee groups behind this. You could detect it in the movement in the wings – people going in and out of a room on the wing. We were aware of it at the time and did our best to detect it. In the visit hall we did a patrol every 15 mins and we had CCTV in places where anyone is suspected or suspicious so that we could keep an eye on things. I did my best, and on a few occasions intercepted drugs and had to put a report in and the Police were informed. Security Information incident reports would be completed and where a resident was implicated, they would be placed on the care and separation and segregation unit.

48. The large number of Time Served Foreign National Offenders (TSFNOs) many of whom were long stayers also created a gang culture and the drugs went hand in hand with that. We made some effort to try and understand how they were communicating and how the drugs got passed from one person to another. They would use special codes for who had the drugs, and who the runners were etc and we would try to figure these out. At one time we noticed that before lock up, some residents would hang towels at the front of their rooms as a signal.

49. The presence of drugs had an adverse effect on the residents as sometimes things felt out of control. Money payments follow drugs and consequently led to violence and fights. There was also conditioning and bullying of residents because some of them would use innocent residents to hide their drugs or to do their shopping from the shop.

It also had an adverse effect upon staff who had to try and control these behaviours. We tried our best to keep things under control and manage on a daily basis, but these issues made it very stressful.

50. The processes were clearly not successful in eliminating the problem. The lack of success in my view was probably due to lack of staff. If we had had more staff, then more drugs might have been detected but drugs are hard to eliminate. If you had more staff it would make a difference because there are more eyes in the room so if I miss something my colleague is more likely to pick it up. This is back at the time. Now it is totally different.

51. I worked as a part of the welfare team a couple of times. I did not have much information about the role but had a fair idea of what I could do. At the time I did not think that there were enough people in the welfare department to resolve the issues. The role involved making calls to the Police and to prisons for lost property, to probation officers, solicitors and case workers. It was a difficult time. Residents were not getting issues dealt with quickly enough. Also, the staff shortage had an impact on the quality of the welfare support being given. If at least 2 or 3 members of staff were on duty, then problems would be solved faster, and we would probably be able to take care of the vulnerable people better. Some training would also have helped. When I was asked to work there, I was helped by my colleagues but did not receive any formal training. There are now more staff in the welfare department.

52. I cannot comment on the process for processing TSFNOs. I was at one point a part of the security team but I was not doing that job, I was escorting residents out to appointments and conducting target room searches or things like that. I have not really dealt with the risks or intel.

Relationships with Staff

53. I was not aware of any racist, homophobic or misogynistic attitudes or behaviours amongst staff during the relevant period. Neither am I aware of staff bringing drugs into Brook House or of any bullying.

Relationship with the Home Office

54. Within the Visits Department we worked with the Home Office engagement officers. They are the link between the residents on site and the case worker who is not on site but is also a Home Office employee. They would conduct interviews of residents and inform them of updates from their case worker and issue removal directions. The Home Office would inform us in advance of removal directions for vulnerable residents and staff and a manager would be present in the corridor when the removal directions were communicated. When it was known that a resident would not be happy to be repatriated the Home Office need a little time to arrange their departure and would need to ensure that there was a team in place to escort the resident to include a medical team where there were medical issues. The resident would be offered a legal surgery which would allow them access to a solicitor and to get advice on appeals and judicial review etc. Legal advice was easily accessible by residents and I had no issues with the Home Office and the way that they managed the removal procedure.

Relationship with Senior Managers

55. I did not really have direct contact with senior managers and cannot comment on the quality of the leadership by senior management. However, I did feel that they would be available if needed. If we needed their assistance, then we would either call them on the phone or could go and see them in their offices on the top floor.

Relationship with DCMs

56. I did not have a lot of contact with DCMs. I did not have a lot of contact with my line manager aside from my annual review. It was difficult for the managers as due to staff shortages there were not enough DCMs to manage things effectively. The DCMs did their best. I had a lot of respect for the Oscars and felt I could go to them if there was an issue.

Relationship with Other DCOs

57. I had a good relationship with the other DCOs and could rely on the team to support me.

Relationship with Healthcare Staff

58. I thought that Healthcare were effective on a day to day basis. There was an onsite surgery in the mornings that detainees could attend, and appointments could be made. Communication between residents and healthcare was easy in my view. I personally did not have any issues with Healthcare and every time I asked them to do anything, they did it.

59. Healthcare were also always available for control and restraint procedures. If use of force was spontaneous when first response was called Healthcare would attend immediately and try to ensure that everyone was safe and establish whether there had been any injuries. If it was a planned use of force event Healthcare would be there at the briefing and would be asked by the DCM who was leading the planned control and restraint whether the resident had any medical issues that they needed to be aware of. Healthcare would accompany us on planned use of force events. They also performed a follow up checking on the detainee regularly after the event. A planned use of force might for example be necessary when we had received a removal direction and it was felt that force might be necessary. However, use of force was always the last resort and the intention was to persuade the detainee to go willingly.

60. However, Healthcare had the same issues with lack of staff and there was a time when they were really busy. This sometimes led to delays in appointments being issued, which caused frustration amongst residents. However, I think they were quick enough to respond when needed. The centre was full at the time. There were about 450/490 residents at the time so healthcare could only do so much, but they did their best to sort things out. I did not ever feel that the residents did not get the attention they needed. Communication was good within the boundaries of confidentiality and in my view Healthcare did their best and provided a good service despite staff shortages. There are no individual incidents that I recall.

Disciplinary and grievance processes

61. I was not involved in any disciplinary investigations into my own conduct or in relation to any other member of staff during the relevant period. Neither was I involved in any grievance investigations. The only investigation I was involved in was post Panorama when the independent investigation team investigated and interviewed

me about my role and what we did. I was never given a copy of my interview notes or statement and as far as I am aware I was not personally investigated or implicated in any way. I have had no grievances raised against me. Neither have I been involved in anyone else's disciplinary or grievances.

Staffing Levels

62. During the relevant period there were staff shortages. There might have only been two officers on a wing and this meant that we could not always give the care and assistance to all of the residents that they needed as there should have been a minimum of three. At the time there would be nearly 120 residents per wing. Two officers simply could not dedicate sufficient time to all residents. We would therefore do what we could to help but this meant that we had to prioritise their needs. It was difficult to both patrol and take care of residents. The low staff numbers also compromised Staff safety making de-escalation more difficult and caused stress and anxiety in officers. The mood was very tense as there was insufficient backup.

63. If there was an incident or a perceived risk to personal safety there was always a first response team that could be called to assist but the members of that team would have to be called from other wings or departments and that would leave those wings and departments short. Because there was an insufficient number of officers on the wing we were sometimes reliant upon our colleagues in the control room watching on CCTV to identify potential issues and call for first response and sometimes first response would be called by control room even before the first officer calls for help, but it was not ideal. In general terms most incidents took place in the Courtyard landing, the servery or the visits corridor and when a resident went for bail or to the Home Office, the corridors would be monitored. The short staffing put us under a lot of pressure and this period was the worst time for Brook House in terms of staffing and incidents and everything else. However, the officers learned how to deal with these conditions and also learned which areas to monitor.

64. The most important thing for officers to focus on would be ACDT checks. There can be two or three detainees from each wing requiring an ACDT check, some could be hourly.

65. Lock up on the night shift was between 9pm and 8am. The night shift began at 9pm. Dayshift were responsible for lock up. At the end of the shift they would pass the figures on to Oscar 1 to ensure that the roll count was correct. If I was on duty, I would go to each level to check the locks and the roll count. Once I carried out the checks, I would release the workers and escort them back to their rooms once they had finished.

66. I have already commented upon staff shortages in Healthcare and the effects upon residents. I felt that this had a negative impact on morale within the Healthcare team but as I did not work in that team I am not best placed to comment.

67. Activities were also short staffed, in line with all other departments. There was an IT suite where residents could go and check emails, a library and courtyards, art and crafts, English classes, pool tables, table tennis tables, a gym, and detainees could play football and cricket in the courtyards. The staff were always short and sometimes I would find myself covering the library or IT suite. I cannot remember any of these areas being unavailable to residents though due to shortages. If there was a staff shortage cover would be provided. I don't feel that the staff shortages in activities really impacted on residents but it impacted on staff morale because it was a further thing to provide cover for.

Tinsley House Staff

68. Tinsley House staff were given the same training as Brook House staff as far as I am aware. However, the environments at Tinsley House and Brook House are very different. Tinsley House is much more relaxed for both detainees and for staff, so they did not face what we faced at BH. This was mainly due to the different type of resident at Tinsley House, which was set up more for families and non TSFNOs. The residents were much calmer and therefore when staff came into Brook House it felt like they were in a new job. At Brook House we had a lot of incidents and aggressive behaviours and physical and verbal abuses, often driven by drugs. Some of the Tinsley House staff coped and others did not feel comfortable. Some adapted better than others. The Tinsley House staff did a decent job however. They tried to give 100% to help out the team. I had no issues with them.

Treatment of Detained Persons

Detained Persons Generally

69. I did not work on reception, but I helped out with easy tasks such as doing searches. However, I did not do any of the administrative work and don't feel able to comment on the arrivals and departures procedures.

70. The Induction Policy has not been made available to me and I am unable to comment upon it. I was not involved in detainee induction.

Activities for Individuals

71. There was an activities programme for residents, and I felt that there was a sufficiently wide range of activities available to them. The activities were very accessible despite staff shortages and the provision felt adequate at the time.

72. I cannot comment upon any activities that might have reduced issues and disturbances.

Immigration Rule 35 Process

73. As I understand it Rule 35 related to torture or threat of torture in the detainee's Homeland and elsewhere. Sometimes I would be asked to translate but that was my only involvement in the process.

74. I cannot comment on how easy it was for residents to be seen under the rule 35 process or how swiftly the process moved as I was not sufficiently involved in it.

Use of Force

75. As I worked on the Visits department, I was involved in a number of use of force incidents. The Visits department is high risk for incidents as that is where the detainees are given their news from the Home Office. When the Home Office issue a removal direction that can be particularly upsetting for the affected detainee and they might display their anger by smashing things such as lockers and chairs etc. We would then try to de-escalate the situation and regain control and that would involve use of force where necessary. De-escalation and communication was the first point of call and use of force was the last resort.

76. I did not have any concerns about any incidents. My experience with the team I worked with was that they were very professional and respectful. Before force was used, we tried to deescalate the situation but sometimes things would be out of control and we had to use force for the safety of the resident and those around him. I felt that the force used was reasonable and proportionate and I never saw any incidents that gave cause for concern.

77. Following an incident there was lots of paperwork to fill out such as an incident report, a use of force report and the supervisors report. Everybody involved hands on in the incident had to complete paperwork plus any witnesses (as part of incident report). So far after the event I cannot remember any individual incidents save for one incident during which I was bitten. I believe that this was in 2017. Reports of all incidents would be held by G4S but I am no longer able to access these. Following an incident there would be a debrief from the manager and an opportunity to consider lessons learned.

78. I had no concerns about any incidents that I was not directly involved in.

79. I believe that control and restraint techniques were necessary and effective to control detainee behaviour. I did not think that they were used excessively. In my experience, they were only used when necessary and reasonable.

80. The only alternative to control and restraint is verbal communication and de-escalation. It was always the first step to listen and talk to the resident to see whether the situation could be diffused and resolved, and force was only used as a last resort.

81. DCMs are required to wear body cameras, which they have to turn on at the start of a use of force incident. However, there could be occasions where the officer would have to respond to an incident quickly and would forget to turn it on.

Involvement in Use of Force Incidents

82. The Inquiry has identified four incidents that I was involved in where force was used to restrain a detainee; 27 April 2017 (D191), 16 June 2017 (D1371), 29 June 2017 (D2953) and 5 July 2017 (D2681).

<u>27 April 2017 (D191)</u>

83. I have considered documents CJS002289, CJS002741 and HOM005920. At the time of the incident on 27 April, I was on A wing. I recall it was dinner time. I became aware of D191 when I noticed his behaviour. It appeared that he was under the influence of a psychoactive substance so I attempted to get him back to his room with the assistance of another detainee. DCM Webb later came to assist.

84. The incident stands out to me because the detainee was so aggressive and he had been in the centre for a length of time. He used to be a worker.

85. Once we got him to his room, the detainee became very aggressive both verbally and physically. He was jumping on his bed with a remote control in his hand and we were not sure what he was going to do with it. The other detainee was trying to talk him down. They both spoke the same language.

86. With the assistance of DCM Webb, we got the detainee down from the bed to calm him down for his safety and those around him. I was not aware that DCM Webb was not wearing a body camera at the time. I had to intervene quickly so I did not consider whether he was wearing one. I was not wearing a body camera because DCOs were not required to wear one.

87. During the incident, I do not recall DCM Webb saying "*If you do not stop screaming you will feel more pain*" however if he did make this comment then it is likely that he meant that if the detainee continued to struggle then it would hurt as opposed to threatening to inflict further pain. In my opinion, the use of force was reasonable and appropriate.

88. The training I received when I joined prepared me to deal with this incident. I used to work at the front gate so physically and mentally I was prepared but the training gave me an advanced knowledge on how to deal with this kind of situation.

89. During the relevant period, it became common for detainees to act in a way that required restraint whilst under the influence of psychoactive substances. I do not know where the illegal substances came from but once they had it, it was very worrying how they behaved. However, we did not always restrain people for abusing or misusing drugs, only when they became aggressive. Sometimes detainees were sent to healthcare but most of the time we would assist them back to their rooms.

16 June 2017 (D1371)

90. I have considered document CJS005565. Use of Force was used during the incident on 16 June because I had to intervene to break a fight up between detainees.

91. There were three or four detainees involved in the incident. I did not know who was fighting who. One of the detainees had a broom stick in his hand and was in the process of attacking another detainee so I stood in front of him.

92. As I attempted to break up the fight, I was bitten by one of the detainees. It was not a large bite wound but you can still see where the scar is. It did not bleed heavily at the time but the detainee's blood was all over my arm. I was sent to the hospital where I saw a doctor and was given antibiotics.

93. I do not have any further details to add to my initial account of this incident.

94. I am unhappy with the support I received from senior management following the incident. After the incident I went home and the next morning I came back to work, submitted my use of force report and filled in the accident pack, no one contacted me to discuss the incident or check on me. In my opinion either the duty manager, my line manager or the care team should have checked in on me.

95. During my return to work, I mentioned to the manager that I was unhappy that no one had checked in on me and she said she would forward this on to the care team so they could speak to me.

96. I have been made aware that the accident pack I completed cannot be found. The health and safety manager has looked for it. As far as I am aware, the accident pack should have been put on my health and safety file.

29 June 2017 (D2853)

97. I do not recall the incident on 29 June 2017. Although I was present at the time, I was not involved.

5 July 2017 (D2681)

98. I have considered document CJS005581. On 5 July, I acted as a translator between officers and an Arabic detainee when he became very upset in the waiting room. He attempted to cause injury to himself so he was put in hand cuffs by DCO Nathan

Harris. I was brought in to assist the detainee with translation in order to calm him down.

99. During this particular incident, the detainee was really upset and crying. He was not following any instructions for us to be able to assist him. He was very distressed and I could see he was tired physically and mentally.

100. It was not a regular occurrence for me to assist with translation, usually it was only if there was a detainee who spoke Arabic or an officer or detainee needed a word to be translated. However, in this particular incident the detainee had just arrived at the centre. He was not engaging or talking so if they used a translator on the phone it would not have been much help.

101. I am not a qualified translator nor have I received any training. I only do it to assist my colleagues or the detainees. I am very comfortable switching between English and Arabic so I am happy to assist anyone.

102. Sometimes I find it difficult when the detainees tell me their story. I have empathy with them, particularly when they have crossed multiple countries to get here. However, I keep my emotions aside so I remain professional.

103. At the time there was no clear instructions on how to deal with a detainee with mental health issues like this gentlemen but I have since had training on this.

104. I recall having a chat with the DCM on shift to explain what was going on with the detainee but I cannot remember who this was. I did not refer the detainee to the mental health services because this was out of my remit but I would like to think that he was referred.

105. On 4 June 2017 I was involved in an incident in which D738 made threats to harm others, himself and reported mental health issues. I reported the matter but I do not remember much about it now. According to the paperwork I have seen, I filled in an incident report rather than a security information report. After reading the incident reports, healthcare attended. However, the detainee was aggressive and threatening people if they went into the room. He was using racial and offensive language and I believe that healthcare feared for their safety.

106. I understand that the detainee was eventually moved to E wing and placed under constant supervision.

107. In my opinion, the actions taken by healthcare at the time were appropriate. I think they do their best to assist everyone, particularly whilst managing their work load and a shortage of staff.

Mental Health Referrals

108. The DCMs are responsible for completing the care plan (ACDT) which deals with referrals.

109. Once the ACDT has been opened it can be shared between staff and the detainee. Different people perform different functions in relation to the ACDTs. Anyone can open an ACDT if they have concerns over a detainee but then a DCM has to take it over and be accountable for referrals.

110. Within 24 hours of an ACDT being opened, a trained ACDT assessor has to assess the care plan. I used to be an ACDT assessor but I gave up the role because of the volume of work. At the time there was a lot of ACDTs.

111. Once the assessment has been done, the manager will sit down and review whether an observation has been done correctly, then they will complete Part C of the care plan which is shared amongst everyone.

Individual Welfare

112. We did not receive any specific mental health training at the time. We got some general welfare training mainly concerning residents' personal hygiene and were taught to spot red flags such as if a resident was quiet or withdrawn. I was alert to that kind of thing and if I had concerns I would report it to my manager. If there was no manager I would escalate to Oscar I and I might open an ACDT. We did our best for resident welfare.

113. I do not feel able to comment upon the role of Healthcare in managing the mental health and wellbeing of residents.

114. I have already commented on drugs infiltrating the centre. Locks Bolts and Bars (LBBs) were performed every day and this included looking to see if detainees had any prohibited drugs or items that shouldn't be in the room. LBB is part of a daily routine to check the integrity of the room to ensure that it is secure. If drugs were found they would be confiscated and declared. Sometimes the control and security department would have a list of room targets. We would do room searches and take drugs away. My role was to confiscate any items and take them to security and file an incident report. Security would do the rest.

115. There was no drug rehabilitation that I was aware of.

116. The role of the Chaplaincy was to provide religious services and guidance. They were also present at ACDT reviews. The Chaplaincy did not raise any concerns about welfare to me.

117. If an individual self-harmed the immediate step was to call first response or medical response to try and preserve their life. They would then be placed under constant supervision on e-wing. As we have higher staffing levels now, we have officers patrolling the wings and building a rapport with residents, and they have more opportunity to prevent self- harm as we are able to be more aware of the residents. At the time, when there were only 2 or 3 officers on the wing that made early detection and prevention very difficult.

118. At the time food refusal would be noted and if a detainee was still not eating on day 3 an ACDT would be opened and they would be placed under observation. At the time I felt it was effective, but I think the way in which it is controlled and handled is now better than it used to be. Now we check every day and if food is still being refused on day 2 the DCM completes a form G, the DCM and sends it to Oscar 1 who then notifies Chaplaincy and Healthcare.

Detained Persons as time served foreign national offenders (TSFNOs)

119. I did not work on reception for TSFNOs and cannot comment on this process.

120. I did not treat them any differently from any other detainees. All detainees were treated equally.

121. To some extent the co-location of TSFNOs with other detainees caused difficulties because they came from prison environments and knew the system and how it works and had also experienced the prison culture, to include violence. A lot of them were Alpha males and would use their experience to their advantage to condition and bully other residents such as overstayers. The overstayers were vulnerable as they were in an alien environment and were not accustomed to it. It created tension. Staff would do their best to stop or manage those behaviours, but it was difficult due to the staff shortages. We had a shortage of managers and some managers would have to deal with two wings at the same time. That made it difficult to oversee what was going on. Now that we have higher levels of staff however, we can give them greater comfort and support and that makes a lot of difference.

Abuse of Individuals detained at Brook House

122. I did not experience any abuse of residents by staff and because I worked in the visits department, I did not witness any abuse of residents by fellow residents.

Complaints

123. If a resident wanted to make a complaint, they could either approach an officer or complete a complaint form. These were freely available in many languages and the same process was followed whether it was a complaint against a staff member or a resident. The complaint would be dealt with by the DCM, the form would then be placed in the Home office box and then passed on to the Home office. The Home Office would investigate and respond, and the DCM will also conduct an investigation. The process for a complaint about Healthcare was the same.

124. I cannot comment on the process for internal investigations conducted by G4S or investigations carried on by the Professional Standards Unit.

125. I do not feel I can comment upon whether the processes could be improved.

The Panorama Programme

126. I believe that the Panorama footage shows me in the visit hall patrolling at around 13.07 to 13.08. I am leaning on a chair in the visit hall next to my colleague. I believe that that is the only time that I feature in the footage.

127. I did work alongside Callum Tully occasionally.

128. The Panorama programme had a negative effect on morale. When we heard about Panorama we were concerned that something might happen in the centre – that we would lose control, that the residents would rebel. That kind of thing. I wasn't aware of the incidents shown. I was shocked by the behaviours and treatments but the programme did not feel like a fair representation of what happened at Brook House and did not capture the fact that some of the people working there tried to do their best and help out. Fortunately most of the resident seemed to share that view.

129. I cannot recall any specific incidents involving underage residents. I am however familiar with the procedures because I work with the HO engagement teams. There are occasions when I have translated for a resident and social care. If we were told or suspected that a resident was underage we would inform the Oscars and the managers at the time and move the resident to e-wing to be assessed by the Home office, healthcare and social services.

130. Following Panorama there was a change at G4S. There were a lot of meetings and consideration of how we could do things better. They were open to new ideas. There were positive changes such as staff retraining, more staff being recruited and improvements to safety measures.

131. I have considered document CJS000763. I do not recall receiving a notification regarding key concerns or issues identified in the Panorama programme. The first contact I remember was a call from one of the managers in August 2021 when I came back from holiday. I was told that I could be investigated or asked to provide comments and they asked whether I recalled anything.

132. I have considered documents CJS005943, CJS004311 and CJS004349. Since then, I attended a meeting where I was further informed about the footage of me on Panorama. As far as I am aware this was to discuss the incident and was not a disciplinary interview. I have not been disciplined as a result of the Panorama programme.

133. I understand that the Panorama footage shows me away from the desk and therefore not monitoring the screen. It was only a small clip of footage. I explained during my

interview that the person who was filming the footage was an officer at Brook House. He was at the desk at the time which is why I left the desk otherwise I would not have left the desk unattended.

134. I have not received any correspondence or had any contact since the meeting. However, I have heard a lot of people have had disciplinary meetings and some have been dismissed following the release of the Panorama footage.

Specific Individuals

135. I worked only with the following officers on the list:

a. Chris Donnelly worked as a manager/Oscar1 and was polite and professional

b. Dave Webb was a DCO and worked on E-wing and is a C&R instructor. He was polite and professional.

c. Charlie Frances – worked on E-wing and was one of the nicest people I met. He was polite and professional.

d. Mark Earle worked in the visits department as a DCO and was polite and professional

e. Bubatunde Fagbo worked in the visits department as a DCO and was polite and professional

136. I never saw any of them using offensive remarks and never witnessed them verbally or physically abusing anyone. I do not know why my name appears on this list as I was not personally investigated or disciplined following Panorama and neither was I suspended or dismissed.

Suggestions for Improvements

137. Since Panorama starting from the top – senior managers and managers have tried to make the working environment as safe as possible for the residents and for the staff. There were positive improvements under G4S but it has got better since Serco took over in terms of communications as the information now gets passed on quickly and effectively and clear instructions are given. We have a lot of refreshers and updates,

everyone now has their own card for log in and emails and there is no excuse for anyone not to pass on information or not to complete their refreshers on line or undertake training. In my view there is nothing really to add now and things are the way they should have been from the beginning. I have no suggestions for further improvements.

Any other concerns

138. I have no further information to add relating to the culture at Brook House or the treatment of residents detained at Brook House that may be relevant to the Inquiry.

139. I am unable to provide a list of names of staff that may be knowledgeable about the matters that I have mentioned in my statement.

140. There are no further matters that I believe are relevant to the Inquiry's work.

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		SLIM BESSAOUD
Signature		Signature
Date		03/02/2022