# BROOK HOUSE INQUIRY

## Second Witness Statement of Jordan John Rowley

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 17 November 2021.

I, Jordan John Rowley, date of birth, DPA of c/o Serco, Enterprise House, 11 Bartley Wood Business Park, Bartley Way, Hook, Hampshire, RG27 9XB, will say as follows:

**Introduction**

1. I provided an initial statement dated 7 August 2021 to the Brook House Inquiry (the "**Inquiry**"), but I understand that the Inquiry has requested further information.

2. I will respond to those questions in the following paragraphs and will incorporate the contents of my initial statement in my responses below. I have adopted similar subheadings to the Inquiry's Rule 9 letter dated 17 November 2021 to structure my response.

**Background**

3. I originally joined G4S as a member of Tinsley House staff in the role of detainee custody officer ("**DCO**") in October 2016. Tinsley House was shut at the time I joined, so following my six week training period which commenced in October 2016, I was assigned to Brook House for a period of around 8 months.

4. I stopped working full time at Brook House in or around May / June 2017, when I was assigned to Tinsley House. However, I was cross deployed back to Brook House approximately two out of five days per week. There was no additional training for Tinsley House staff. We were briefed on what the regime was like before it opened, but we were expected to 'get on with it'. Staffing levels were low as we were constantly cross deployed back to Brook House.

5. I worked at Tinsley House for a further two years, before joining the pre-departure accommodation team which is based at Tinsley House in July 2019. I remained in this team until May 2020, when I was transferred to the activities department. I am currently a Gym & Sports Officer.

6. Whilst working at Brook House between 1 April 2017 and 31 August 2017 (the "**Relevant Period**"), my primary role was to assist on the visits and residential halls. This involved working on the wings of Brook House and also assisting residents who had social visits or meetings with the Home Office. This might include, for example, collecting a resident, taking them to their meeting, monitoring them during the visit and then taking them back to their room.

7. I joined G4S as I thought it would open more opportunities for me and I did not want an office based job. The recruitment process was explained fairly thoroughly, so I understood what Gatwick Immigration Centres involved.

**Culture**

8. When I first started at Brook House, the wings and other areas were very understaffed. There were two DCOs per wing (this slowly increased to three DCOs over time) and each wing held a maximum of 150 detainees. As a member of Tinsley House staff, I would provide cover wherever needed and assist on all the wings, including visits. When there were two DCOs per wing, it felt dangerous managing a wing when one of the other DCOs had to go to the toilet, or go to escort a resident to reception, leaving one DCO to manage the wing on their own. By the

time I moved to Tinsley House, there were three DCOs per wing, with two activity staff attending each wing to conduct activities. I was not aware of healthcare staff numbers, but always thought that they were fully staffed.

9. Staff had a good rapport with residents on the wing, but staff morale during the Relevant Period was low due to being overworked and exhausted. This did not necessarily affect how staff treated residents, but it meant that staff did not have enough time to stop and chat to residents at length and build rapport. I felt that I had enough time to do my job, but not enough time to build relationships with residents, which meant, for example, that de-escalation during an incident may be more difficult due to the lack of personal connection. I did not witness staff treating residents any differently as a result of the workload.

10. I did not have any particular concerns about how staffing levels impacted upon the general protection of residents, the management of staff, or the protection of vulnerable detained persons.

11. If there was an emergency, we would call first response and one person from each wing would attend to the emergency. With regard to the management of staff, management would always help. Since Serco has taken over from G4S, the number of managers has increased and now a manager is placed on every wing, rather than previously, where a manager would usually just attend in the morning. Especially vulnerable individuals would usually be placed on E-wing, which allowed them to be monitored more effectively due to the size of viewing panels on the doors. I believe that there were always sufficient staff to deal with especially vulnerable individuals.

12. In relation to management, when G4S operated Brook House, I did not feel that we were really 'managed' on the wing. There would be an average of three officers per wing (referred to individually as Charlie 1, Charlie 2 and Charlie 3). A manager (referred to as Oscar 1) would attend the wing each morning to explain to Charlie 1 how to run the wing / what needed to be done. Charlie 1 would make sure that

everything was completed and then report back to Oscar 1. Once Oscar 1 attended the wing in the morning you may not see them again on the wing that day. During the Relevant Period I was relatively new and did not have experience in this sector. Prior to working at Brook House I worked as an administrator in an office based role. Therefore, I did not know any better at the time and accepted this to be normal.

13. In my opinion, the key value / priority for senior management during the Relevant Period was looking after vulnerable residents and making sure that ACDT booklets were up to date. An ACDT would be opened on the occurrence of an event which triggered the need to monitor a resident and effectively devise and implement a care plan to protect their interests. These booklets contained information on the triggers for a specific resident and the plan that was put in place. Certain residents who demonstrated a trigger, for example, self-harm, would be interviewed to find out why they were self-harming and why they were vulnerable. There was also a section to write up observations about self-harm, depression etc. Only the most vulnerable residents had an ACDT booklet opened. For example, if someone had self-harmed or there were concerns about mental wellbeing or refusing meals. The opening of an ACDT would lead to health care or chaplaincy involvement and a multi-disciplinary team would devise the appropriate plan and implement and monitor it. One detainee may have no ACDT booklets opened, whereas others may have several.

14. I did not see senior management too often. The team on the wing were very good and experienced. We would only really need management if we were stuck or if there was an incident. Everything else on the wing was quite manageable and I do not recall needing constant support. The other DCOs were more experienced than I was and I could always seek their advice if required.

**The Physical Layout of Brook House**

15. Brook House is very much like a prison compared to Tinsley House, in the shape of a 'H'. It is like a maze due to the number of doors you are required to go through,

but you soon get used to the layout. E-wing is a very small wing compared to the others. It is where vulnerable residents or residents with medical issues were located. CSU was also attached to the end of E-wing.

**Policies and Procedures**

16. Policies and procedures were explained on a PowerPoint presentation during the early stages of our training. They were rarely used or refreshed during the G4S period of operation. We were supposed to have yearly staff refreshers to go over policies and procedures, but we were too understaffed to carry out such refreshers.

**Training**

17. I started my training course in October 2016. This largely consisted of PowerPoint presentations and trainers talking through policies and procedures, including health and safety, fire marshal training, first aid level 2 and use of force ("**UOF**") training.

18. UOF training was provided to me during my initial six week training period. The UOF training was provided over the course of five days. The first day involved a PowerPoint presentation style session learning about the laws of UOF and what was and was not permitted. This was followed by practical training from UOF instructors.

19. In my view, the UOF training prepared me for my role at Brook House when involved in restraint incidents. However, you can never train for each individual scenario because each one is different, for example, you are trained to deal with weapons, but other residents may get involved. Each incident was different. The delivery of UOF training was very strict. There was a lot of attention to detail and if you failed the course, you would be given a second chance. If you failed to complete the course on your second attempt, you would not be able to pass to become a DCO.

20. Refresher training was provided once per year every year for UOF training and first aid. This was beneficial, especially for those who were not involved in UOF incidents during the previous year. All DCOs had to attend these courses and there were no additional courses for activities staff at that time. I am unable to recall the dates of every refresher that I attended, but the most recent one occurred in July 2021. I have never allowed myself to go over the annual refresher date, but if it ever expired, I believe the manager would not allow you to be in residential areas.

21. In terms of improvements, I think that UOF refresher training should occur more often, such as, once every six months instead. This is because during the year you may forget how to undertake specific holds. Furthermore, I recall the training on 'cuff-carrying' (where a resident needs to be handcuffed and carried as they are unwilling to move themselves safely) was brief and provided at the end of the session. I received further training on this after the Relevant Period, but on reflection, it would have been useful to have received more detailed initial training.

**The Role of a DCO and Relationships with Detained Persons**

22. I was not a DCO in 2009 as I started my employment in 2016. I came from an office based job, so when I went live as a DCO, I did not know what to expect when I entered the wings. Some residents were approachable and easy to talk to, whereas others were not. Where residents could not speak English, other residents might translate for them, or Big Word on my phone would be used.

23. ACDT training was very thorough and was quite strict on what could and could not be done, and what risks were involved using a constant watch or regular check. As far as I remember, ACDT checks were reviewed every 24 hours on a constant watch supervision, with a review per hour within opening an ACDT.

24. I did not work in the welfare or security team.

25. There were numerous mechanisms to prevent drugs from entering Brook House. One of the key ways was via searches. Staff would be subject to random searches by the security team and this would sometimes involve sniffer dogs. Random searches on staff would occur once every three weeks. This would involve staff being immediately sent to be searched on arrival to Brook House, so they could not, for example, place items in their locker before being searched. Searches were also conducted on residents where staff had received intelligence that they were in possession of drugs or there was a suspicion. Adult visitors were subject to level-A searches i.e. clothes on searches and metal detector searches at every visit. Children were 'wanded' with a metal detector. Visitors would also be monitored during their visits.

26. In addition to searches items received by residents, for example, radios, might be x-rayed. Post would also be photocopied and provided to residents to prevent any drugs sprayed on the letter being smuggled in.

27. In my opinion this process was successful, but residents still managed to smuggle in drugs in ways unbeknownst to us. I believe that residents who were caught bringing drugs into Brook House would have had the drugs confiscated and the matter would be reported to the Police. The resident would also be subject to a 'removal from association' rule 40, which prevented them from leaving their room. This would be reviewed every 24 hours.

**Relationships with Staff**

28. While I worked at Brook House, I believed that staff got on very well as we had to constantly work together for long periods of time. I was not aware of any racist attitudes or behaviours or any homophobic and / or misogynistic attitudes or behaviours.

29. I do not recall at what point I became aware that a staff member, the onsite shop keeper, had allegedly brought drugs into Brook House. I had only heard a rumour

circulating at the time. I do not know their name and believe that they worked for Aramark in the shop. I was not aware of drugs being brought into the Centre by staff until this point.

30. I did not experience any bullying at Brook House and did not have any concerns about other staff being bullied. I did not have to deal with a staff complaint regarding bullying, or act as a witness in any process.

**Relationship with the Home Office**

31. The Home Office were not really seen on the wings. The only time I would see a member of the Home Office was when I worked in the visits department and had to arrange interviews with residents. From what I remember, Home Office staff were friendly and polite.

**Relationship with DCMs**

32. DCMs at Brook House during G4S' period of operation were very understaffed. However, they were very experienced and good at handling residents at difficult times. I believe that they were busy with paperwork, but they always came to each wing to make sure everything was running smoothly and would always attend first responses when called to an incident.

**Relationship with other DCOs**

33. I believe that most DCOs got along really well and could rely on each other to get work completed on time and to protect each other.

**Relationship with Healthcare Staff**

34. In my experience, healthcare always had good rapport with residents. They would attend all medical emergencies and first responses when called in an efficient

manner. I believe that they made sure that residents who required regular medication on a daily basis were always managed very well.

**Disciplinary and Grievance Process**

35. Aside from the matter referred to below, I did not have any disciplinary or grievances against me, or recall any that I have witnessed.

**Treatment of Detained Persons**

36. I have never worked in reception and am unaware of the processes in reception.

37. As far as I am aware, the activities staff attended each wing to conduct an activity, for example, pool competitions, football or cricket. Activities took residents' minds off the stress that they were dealing with and allowed them to enjoy the sport. Big events, like boxing or the World Cup, would be shown on a projector on a big screen on each wing.

38. As far as I recall, detainees would show me a slip that they had a rule 35 meeting with a time slot on it and I would have to escort them to the doctor's clinic for a review.

39. When I first started, UOF was quite popular with other officers on other wings, but not with me. I was involved in a few UOF incidents for planned removals, but I do not recall all of the dates.

40. UOF techniques were effective when dealing with an incident or an aggressive resident. Appropriate and proportionate force was used and no more force than was necessary.

41. We only had one training session on mental health awareness but this was never refreshed. We were taught how to identify different mental health issues.

42. Drug rehabilitation / support took place in rooms 1 – 3 on E-wing, so they could be closely monitored by staff and regularly checked by healthcare.

43. The Chaplaincy team included staff who had a lot of knowledge regarding religions. They would attend ACDT reviews and regularly visit wings to offer help to residents and carry out religious prayers in mosques and chapels.

44. From my experience, if a resident self-harmed, the first officer would call a medical response over the radio and healthcare and a manager would attend the location of the incident. The first officer on the scene would immediately start to treat the resident with a first aid kit and patch wounds, or ensure that the resident was breathing. Working together as a team worked efficiently and all residents were treated or taken to hospital if needed.

**Detained Persons as Time Served Foreign National Offenders ("TSFNO")**

45. Some TSFNOs were treated the same as everyone else, whereas others had a prison attitude, for example, they may call you 'Gov', which I believe is short for 'Governor' in prison. Most TSFNOs are approachable and cooperative, but others are not.

46. I am not aware that I had any concerns about verbal abuse towards myself or others.

**UOF against D1234 on 28 March 2017**

47. This was one of the first UOF incidents that I was involved in at Brook House. I do not wish to make any amendments to the statement that I provided at pages 22-25 of document HOM002496. However, I note that this was one of the first UOF reports that I completed and I did not receive any help drafting it. The report was completed when I was fatigued following the UOF and at approximately 10 p.m., one hour after I was meant to finish work for the evening. Therefore, in hindsight, I would have added more information and detail regarding the position D1234 was in when handcuffed and the cuff-carry to discharge process.

48. Due to D1234's positioning, I was unable to fit in between himself and the bed so I was crouched in a squat position. Due to my relative inexperience, I was following my manager's (DCM Steve Dix) instructions to sit D1234 up. I recall that the cuff-carry was not the best cuff-carry, as the resident was naked and therefore a fellow staff member was trying to cover D1234's dignity. D1234 was kicking staff throughout this process which made the UOF more difficult. At the time, I was not aware of the removal of the technique of placing a resident in handcuffs whilst seated. However, I have since had this training. For this reason, I did not challenge the technique at the time. I was focused on securing and getting a lock on the arm. I was also surrounded by experienced individuals who were directing me. I followed my manager's direction as I thought this was the correct thing to do at the time, especially when I could not see what was going on around me / other staff member's positioning and holds.

49. I believe that I conducted the UOF in the best possible manner given the circumstances and in accordance with my training. In hindsight, I would have tried to get D1234 into the final position to enable me to gain more of a secure lock. I had his arm in a straight arm lock rather than a final lock which is more secure.

50. As detailed above, I had received training on how to cuff-carry a non-compliant resident, but this topic was covered briefly towards the end of the training. In general, I consider the C&R training prepared me for UOF incidents at Brook House. However, it could not prepare you for every scenario as all situations are different, for example, detainees may cover themselves in oil and faeces, or they may place washing up liquid on the floor. These would all make the UOF more difficult and we were not taught how to respond to such challenges.

51. Prior to this UOF we received a briefing which provided details about the resident, previous levels of aggression and any other concerns, for example, the fact he had removed his clothes in protest. At the time we did not receive information about the height and weight of the resident, as we do now. Throughout the removal process, I felt that DCM Dix was clear on who he was talking to and was able to give orders.

Graham Pernell was also observing DCM Dix so other senior managers were involved. Due to the passage of time I am unable to recall the debrief provided by DCM Dix, so I cannot provide any comments or feedback.

52. In relation to D1234's statement in document HOM002492, I did not witness D1234's head being violently turned, his throat being held or his toes being stamped on. I was certainly not involved. I have seen some footage available online from Day 14 (10 December 2021) of the Brook House Inquiry Live Stream on YouTube (timestamp between approximately 5:01:00 and 5:18:31). This footage is body-cam footage of D1234's removal and I cannot see any evidence that the above actions were undertaken by my colleagues or I.

53. Once Brook House staff had completed the removal and handed the resident over to Tascor staff, we were told to sit down and rest. The video footage shows D1234 being handled by numerous individuals who I believe are Tascor operatives, so I can only assume that the actions described by D1234 were conducted by them after we had conducted the removal process. I believe D1234 is mistaking the interaction he had with Brook House staff, with his interaction with Tascor, which to my knowledge is a separate entity and was not a part of G4S.

54. Throughout the removal, D1234 was constantly shouting / chanting, so I did not hear him specifically scream for help or express that he was in pain. I was focused on listening to my manager and on getting safe and secure locks on D1234's arm.

55. I was not interviewed by the Professional Standards Unit ("**PSU**") following the UOF against D1234 and I was not aware that there was an ongoing investigation. The PSU only gets involved with certain UOF incidents, as far as I am aware. If there was an investigation, as someone involved in the UOF, I would have expected to have been interviewed and I do not know why I was not.

**UOF against D2159 on 5 April 2017**

56. I was instructed to help with the relocation of D2159 to a more suitable location on the medical E-wing due to his food / fluid refusal. E-wing is smaller and people are taken there if they need closer monitoring. I understand his refusal was affecting his health and wellbeing. D2159 refused to leave his room, which was situated on the top floor of D-wing, which made it difficult for us to monitor him. From memory, he also did not speak.

57. In relation to my account at pages 16-20 of CJS005529, I would amend the following. Where I state: *"While still in figure four arm hold we sat on the left side bed and DCM Dix took the handcuffs off and advised we will let go of him now"*, I did not mean a figure four arm hold, I meant I had D2159 in a secure hold whilst in handcuffs. This was an error in drafting the statement. D2159 was in handcuffs, so could not have been subject to a figure four arm hold at the time.

58. I believe that the UOF was necessary and proportionate in the circumstances. We used minimal force to move D2159. We have three medical rooms on E-wing which would have been a far better environment for D2159, where he could be closely monitored. It would have been difficult to consider any other options, as D2159 did not communicate with staff or residents and stayed in his bed. He did not move except to use the toilet. I believe that we did not have any other options as no other options were feasible.

**UOF against D1765 on 7 July 2017**

59. I do not recall how D1765 sustained an injury to his leg. I remember that upon entering the room, D1765 was lying down under the duvet of his bed. D1765 may have sustained the injury before and I understand that one of my colleagues had noticed a dried blood stain, so this may have been a previous injury which reopened during the UOF. D1765 had a history of self-harm using blades, so the injury may have been caused in that manner, but I am unable to comment with certainty.

60. Health care nurses were present throughout the removal, but they do not inform us whether they have checked a resident prior to removal. Typically, a manager would check on a resident prior to any relocation, to establish whether there would be any issues with the relocation. Injuries may be spotted during these checks. There were no concerns during the removal of D1765 and health care nurses did not step in.

61. When D1765 was passed to Tascor, they placed a restraint on him as he was fighting. Tascor brought D1765 back when they saw the bloodstains. I personally did not ask the health care team to examine D1765 prior to the removal, as there was no reason to do so and it was not standard practice.

62. If a resident sustains an injury during a UOF incident, depending on the severity of the injury, the team would adjust their holds to allow health care to assess the injury / concern. The team may even go into a medical emergency. A medical emergency could be called with or without health care if a concern is serious, for example, someone going limp, or any threat to life. Once a medical emergency is announced, the team would kneel and make space in the room to allow health care to check the detained person. Health care can confirm whether to stop the UOF or not.

63. The Inquiry has asked me to comment on D1765's position regarding the debrief form. I am unable to do this as I was not present when this form was completed and I am not sure what form the Inquiry is referring to. If the Inquiry is referring to the health care debrief form, I believe D1765 was taken straight to hospital to get stitches, so I am not aware of any debrief. If the Inquiry is referring to the document at page 25 of CJS005594, the answers on that form appear correct to me.

64. Following the UOF on D1765 I did prepare a statement which was given to the Oscar 1, Nick London, so I am not sure why it is missing from the report. To my knowledge it is not on the Egress account. You would not be allowed to leave Brook House until a statement was provided.

65. Overall, my role in this UOF was to be the head support officer. This person enters the room first with a shield and once the arm officers have gained control, the head support officer places the shield behind them and takes hold of the resident's head. My role was to support the team and guide the team to where directed by the supervising officer. The supervising officer is the manager and oversees the UOF. He instructed the team to put D1765 in final locks and I instructed the team where to take the detainee.

**Individual Welfare**

66. I am unable to recall when I attended the training session on mental health awareness. I believe it was around one or two years after joining Brook House. The training taught us to recognise signs of depression or other mental health issues. It was one session with an external person and I found it useful in supporting me in my role.

67. The health care team provided the primary role in managing the mental health and wellbeing of residents at Brook House during the Relevant Period. Upon arrival, all residents were assessed and could be referred to receive support if required. Similarly, if residents deteriorated during their time at Brook House, they could be referred. The health care team had a mental health nurse and we could book appointments with this nurse if we had concerns. The resident could then have discussions with the nurse and be diagnosed in relevant cases.

68. If I was assigned to the induction wing (the wing residents are placed on for an initial period when joining Brook House), I may be involved in managing resident's mental health and wellbeing. On the induction wing I would conduct observations and raise concerns if I had any, for example, if I witnessed a resident talking to themselves or being violent towards themselves. I understand that individuals joining Brook House undergo an assessment on arrival, where they are asked questions about their mental health, for example, whether the individual has suicidal thoughts. The individual is then subjected to a 24 hour review and the same

questions are repeated at the end of this review. As a DCO, I may also open an ACDT if I observed signs of declining mental health, depression, self-harm and / or food refusal.

69. There were various procedures in place at Brook House, including the 'raise concern' process, the ACDT process and the supported living plan. A supported living plan can be opened when there is a physical need in relation to a resident. They are designed so that for example, if there is a fire, a supported living plan resident would be collected to make sure that they leave the wing safely.

70. Save for the procedures described above, I am not aware of any specific policies in place that prevented drugs from entering Brook House or being used.

71. If an individual refused to eat the food provided, a manager would be informed and an officer would ask the resident why they were not eating. The resident would be closely monitored at dinner time and if they were refusing to eat, their food would be served directly to them in their room. If this continued, an ACDT may be opened and the resident may be admitted to hospital.

72. From my experience, sometimes residents would refuse to eat their meals, but then eat food from the shop. Therefore, we would look to see whether there was evidence of this within their rooms, such as food wrappers. This was all part of the monitoring process. Sometimes it was quite difficult to monitor this, as they may be asking other residents to purchase their food for them.

73. I felt that this process was effective, but it was my first role in this setting, so I did not know any better. We could not force residents to eat, so this was the best we could do.

**Abuse of Individuals Detained at Brook House**

74. On 21 April 2017, I was working in visits when officers were asked to attend an incident on the radio. The incident related to two residents who were refusing to go back to their rooms for roll call. I recall that two residents were sitting on the 1st floor pool table and one of my colleagues, DCO Babatunde Fagbo, had asked one of the residents to go to his room. I remember that the situation became a little heated. DCO Fagbo was repeating the order for the resident to go into his room and the resident was saying 'make me go to my room'. All DCO Fagbo could do was repeat his initial instruction. Eventually the matter was deescalated by a female officer. I was not involved heavily as if lots of officers get involved it can be deemed excessive. To my knowledge, I recall asking D119 to go to his room politely multiple times, but he was so focused on DCO Fagbo that he ignored my request.

75. When I stated that DCO Fagbo was too 'full on' in how he handled the incident, I meant that he had tried to take control of the situation by himself. In such situations, if you are not getting anywhere with a resident, you should radio a manager for assistance to deal with the situation. DCO Fagbo did not do this which is why I described it as 'full on'. I did not raise any concerns with DCO Fagbo or senior management as the situation was resolved. Furthermore, I personally did not hear anything which caused me any concern.

76. I did not see any gestures from DCO Fagbo or hear him use the inappropriate language referred to by the Inquiry, as I was facing in the opposite direction. I do not have any comments on the findings reached by G4S.

**Complaints**

77. For staff, we had a 'speak up system'. This was discussed in our training. It is a whistleblowing system on the intranet where you can report issues with staff or bullying anonymously. Alternatively, you could complete a security incident report ("**SIR**") form and send it to security to deal with by management. I believe it was an external G4S group who would deal with those reports. I do not know whether this system was implemented after the Relevant Period.

78. All residents could get a complaint form from wing staff. The Home Office would collect forms from the form boxes on each wing every morning.

79. In the first year I was at Brook Drive, there was a resident who was very loud and abusive to staff on A-wing and I witnessed him trying to recruit other residents to try to take over A-wing. I completed an SIR form and delivered it to the security department myself. Action was taken to remove the resident from the wing and he was placed into CSU and was spoken to by senior management. I believe the seriousness of the incident was dealt with quickly and efficiently and prevented the wing from being lost to a resident. It also prevented people being harmed.

**Disciplinary**

80. I was completely unaware of the incident referred to by the Inquiry on 4 March 2017 in document CJS0073125. I was shocked when I saw it and do not recall anything about it.

**The Panorama Programme**

81. Callum Tulley was an activities officer and attended each wing to play pool with residents. I believe I had a good rapport with Callum when he attended the wings.

82. I do not appear on the programme. Following the programme, officers were desperate to leave Brook House and the staff that appeared on the programme were suspended. This left the wings extremely short staffed, to the point where most DCOs did not get a lunch or dinner break in a 13.5 hour shift.

83. The new staff employed was a positive step, but it meant that new staff were shadowing relatively inexperienced staff. This was difficult and caused issues in building rapport with residents. The increased number of staff meant that my cross

deployment from Tinsley House reduced to around one day per week and generally, the situation improved over time as people became more experienced.

84. In the long term it made work easier as there were more staff to share the workload with. All staff were also provided with body cameras following the programme, which increased protection for staff.

85. Following the programme, most detainees were verbally abusive towards the Home Office and G4S, rather than anything personal towards us.

86. I was not aware of the underage dispute and was not involved in this.

87. As far as I am aware, G4S increased the amount of staff to help numbers on the wings, but I did not notice any further changes. When Serco took over from G4S there were a number of improvements, for example, residents could select what food they wanted for the next day from the kiosk which saved time, associations were conducted via time slots so you did not require a residential officer at the door constantly (which freed up an officer) and generally staffing levels were far better. Due to COVID, staffing levels are going down again, but it is a lot better than previously.

**Specific Individuals**

88. I have worked with all of the individuals listed by the Inquiry in its initial request for information, but most of them worked on different shifts to me. When I did work with them, they always respected residents and worked in a professional manner. I did not witness any incidents of verbal / physical abuse towards residents or staff.

**Suggestions for Improvements**

89. Since Serco has taken over staffing levels have improved, but the shift pattern has been made worse. More experienced staff keep leaving and most new staff are running the wings.

| **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.<br><br>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 | Jordan Rowley |
| Signature | **Signature** |
| Date | 06/02/22 |