BROOK HOUSE INQUIRY

First Witness Statement of Ryan Matthew Harkness

I provide this statement in response to two requests under Rule 9 of the Inquiry Rules 2006, dated 15 June 2021 (the Initial Request) and 4 November 2021 (the Further Request). To assist the Inquiry, I have structured my statement as per the order of the questions in the Initial Request. My answers to the Further Request, are inserted at suitable points within my response to the Initial Request. Where the Inquiry has asked a question which has not been covered within the Initial Request, I have provided a response at the end of my statement under the sub-heading 'Additional Responses to the Further Request'.

Background

I Ryan Matthew Harkness, date of birth DPA will say as follows:

1. I am currently a Detainee Custody Manager (DCM) at Brook House, Gatwick, which provides accommodation for asylum detainees. I began my training for my role at Brook House in April 2017 as a Detainee Custody Officer (DCO) and was promoted to the position of DCM in January 2018. Prior to that I had worked in the leisure industry for approximately 10 years, from the age of DPA I then joined the RAF from the age of DPA following which I joined Fire and Rescue.

Application Process

2. I was attracted to the DCO role as I had been out of work and it looked interesting. The application process involved an on-line assessment in Maths and English as well as problem solving questions. I then got invited to a day's assessment during which we participated in team-work activities. We watched a video of what to expect and underwent an interview process and completed a health declaration. I can't remember the content of the video. I then received an offer of employment, following which I underwent a 6-week training course.

3. The recruitment process didn't prepare me for the role. None of it seemed relevant to the reality of the job. But I believe that nothing could have adequately prepared you for the role at that time. The conditions back then were very different to conditions now. I had no experience and didn't know what to expect. I started the initial 6-week training course in April 2017, but I still didn't know what to expect. The training was divided into segments relating to how the place works, the paperwork side of things, the detention and custody rules, the escort requirements etc. It essentially covered your day to day role in sections. I believe we also conducted some role play. I passed the initial training course in May 2017. Following the 6 weeks training you theoretically went live, but you had to await CSC clearance before you could interact with residents and, during that time, I was placed on the gatehouse performing control room and gatehouse duties. My clearance was delayed, and I didn't start normal duties on the wings as a DCO until July 2017.

4. It was a little bit of a shock when I started and not what I expected. I didn't feel prepared for what I came into even though I had had some feedback because I was one of the last to join due to delays in completing my clearance. I started on nights and I remember coming through the wing door on the first night. They were locking up. As I did not know what to expect it seemed like uncontrollable carnage and I found myself immediately having to challenge residents to get them to go through their doors. Some of the residents were banging doors and shouting and screaming – nothing prepares you for that. Back then I think maybe the issues stemmed from the type of residents that we had (there were a lot of ex-HMP residents), as well as the lack of staff support and confidence.

5. As a DCO, I was predominantly based on D wing. My role as DCO involved looking after the welfare and safeguarding of residents. This included, for example, listening to their concerns and providing solutions where possible. By way of example, I might be asked to provide them with extra bedding, assist them with sending faxes, or provide them with assistance in relation to their case. Depending on the severity of a concern, I would escalate as necessary.

6. The key challenge I faced as a DCO was the amount of residents per wing, in comparison to staffing levels. There were also many different personalities, so it was quite an intense atmosphere.

7. I was promoted to DCM in January 2018. My role was in 'Paid Work', which meant that I was responsible for recruiting residents to do paid work around Brook House. I also had to ensure that the cleanliness of the centre was of a good standard.

8. The key challenges in this role were keeping motivation within the work force high and removing residents from paid work if they were in breach of Centre rules. There were around 150 positions within the workforce, for example, cleaners and kitchen staff. For certain roles there would be a vetting process, such as those where there was access to sharp implements or chemicals. In such cases, we would put the information on a spreadsheet which was reviewed by security, healthcare and the Home Office and they would work out the necessary clearances.

9. Residents often approached me to ask what paid work was available. I wanted to make the process as professional as possible and would discuss what positions were available and what position the resident would be most suitable for. They would then sign a contract and be put forward for the role. It was akin to an interview process, as I was trying to prepare them for work outside of Brook House. I always wanted the residents to feel like part of a team.

10. I often found that as the person responsible for paid work, and essentially their money, I had a better relationship with residents. I would always make sure that if there were any issues about paid work, I would have a conversation with the resident to include them as part of the team.

Culture

11. There wasn't an identifiable culture at Brook House. The atmosphere and therefore perhaps the culture was a bit mixed at the time. It was different to how it is now. There was a mixture of experienced staff and inexperienced staff all of whom did

their best. Staff morale was shocking as we were completely understaffed. It felt dangerous - you had wings that held 146 people and often only 2 officers on the wing (3 if you were lucky) – they had to do the paperwork and man the doors and there was no one permanently on the corridors. When the office was closed you could do the room inspections, but because of the low officer numbers you might find yourself going into a room by yourself and challenging residents and removing items from them. Staff shortages influenced our ability to undertake our roles, as it meant that there were fewer people available to assist with tasks, which increased pressure and stress. Inevitably, the reduced number of staff placed staff members at greater risk.

12. The attitude towards residents would vary depending on the calibre of the officer and confidence. Because of my age I had a different perspective and approach to some of the younger officers. In my opinion the younger ones were sometimes overly friendly and relaxed with the detainees. For example, they would allow residents from different wings to mix or would provide residents with additional bedding, or allow them to keep drinks in the staff fridge and even bring drinks to the residents' rooms – it was almost like room service. It felt like there were no boundaries. I believe that a major driver for such behaviour was a feeling of intimidation particularly amongst young and inexperienced staff because of the environment that we were in. There could be 146 residents, many of whom were screaming and shouting and banging on doors. There was violence and drugs on the wings at the time and the atmosphere could get tense. It was particularly intimidating for the younger less experienced staff who, I believe, were trying to establish and maintain a friendly relationship with the residents, so that they would blend in and be viewed as one of the gang so that they would not become a target.

13. I did become a target to some extent initially because I would challenge behaviours firmly. Once the residents got to know me and my approach and understood that I had a military background and would not be persuaded to depart from procedures, but would maintain boundaries, they accepted that. I had a good relationship with them and would have a chat and a laugh with them when I could, but I was firm and consistent and they knew it. When I came on shift, for example, they would

voluntarily hand over extra pillows that they might have been given on previous shifts because they knew that when I did the room check I would remove them. However, these behaviours by staff were contrary to the procedure and created inconsistencies which caused problems with maintaining regime and discipline. I found it tiresome as I sometimes felt I was the only one challenging behaviours on a regular basis. In addition, even if I succeeded in re-establishing structure and order during my shift, I found that when I returned for my next shift I would often be back to square one.

14. I complained about it but didn't formally report it. I didn't see the point in reporting it, not least because I had had a disagreement with one of the residential managers about allowing residents' drinks to be kept in the staff fridge. I believe that management were aware of the issues but did nothing to address them. I simply continued to enforce the rules regardless.

15. There was never however any aggression by the staff towards residents that I ever witnessed despite the sometimes difficult working conditions. If anything, my concern was about over-friendliness and relaxation of rules and boundaries and the problems that that would cause in maintaining order and discipline.

16. I couldn't really say what G4S values were. In my view it wasn't security and safety. When we were on the floor we didn't see management or senior management. The roster was gruelling. We had 13.5/14 hour shifts with half an hour break. I would return home, have 6 hours sleep and then get up and do it again.

17. The way in which the centre operated at the time in my view potentially encouraged violence and aggression between residents. It was a difficult time but in my view the policies and procedures were in place for protection – the boundaries were there but they weren't being enforced. Allowing residents onto other wings might seem harmless enough on the face of it, but it wasn't just about residents wanting to visit their friends. Sometimes there was a hidden agenda be-it drugs, hooch or debt related. The procedures provided for ID to be shown on the

wing door and if someone was not from that wing they should not be permitted onto it. However, some of the staff had been conditioned so that they wanted to be friends. Staffing levels were shocking and there was no effective over-sight of the officers.

18. I didn't deal with vulnerable residents so I do not feel that I can comment on the impact upon them. They were generally safeguarded or were on an ACDT or were put onto E wing. However, staff did have a good relationship with all of the residents. They talked to them when conducting LBBs, they would engage and play pool with them if time allowed and we would ask them about what they had been doing and what activities they might have engaged in. In my view the staff did their best to ensure the welfare and protection of the residents. Generally, those on ACDTs were the number one priority for staff and their needs were always put first.

19. I couldn't say what the management or leadership culture or the values and priorities were. The safety and welfare of staff didn't seem to be a priority. Management were not visible. In my experience, unless there was a first response called on the radio, you would never really see managers. However, the management back then were so thinly stretched. There were 3 residential managers but I only saw 1 and then very rarely.

20. I did not have any concerns about the treatment of individuals, and I heard nothing negative about staff treatment of residents. With regard to the behaviour of residents towards other residents, I sometimes had concerns but that depended on the staff member on the door and whether the mixing of wings was likely to be permitted. There was always a general concern that residents would fight.

Oversight, monitoring and outside involvement

21. I know nothing about the November 2016 HMIP inspection and am not aware of victimisation.

22. The Independent Monitoring board are here for the residents and staff to ensure that the treatment of residents is good, that they are given proper provisions ranging from quality of food to temperature of rooms, access to phone-calls or Home Office interviews and provision of information from welfare. I am now the sports manager so they may take an interest in anything to do with activities whether it be the availability of games consoles, or any issues with the pool tables or the table tennis tables, or whether we are ensuring that residents have access to arts and crafts, IT, Skype and the gym. They have an eye to anything that we are failing to provide, and they walk around and speak to both residents and staff. They come around every other day and in my experience they listen closely. They are here to right any wrongs and, if things can be done better, they make sure that that happens. I have a good working relationship with them. Whenever there is an issue or when they do their walk arounds during lockdown we go and chat to them. There is a complaints box for the IMB and Home Office on every wing. The residents can fill in a complaint form if they have any issues. Complaints may be quite simple – for example, there not being enough activities or board games or a resident's room being too warm. The IMB investigate every complaint.

23. I don't have any direct experience of the Gatwick Detainees Welfare Group and I have never heard of Bail for Immigration Detainees. I am now based in the activities department and therefore don't really have anything to do with them.

Physical Layout of Brook House

24. I think the layout of Brook House is good. The activities corridor runs through the centre – the core of the building. The building is shaped like an H and the central hub contains everything and that is the part of the building that I manage. There is always room for physical improvement – for example we could remove the suicide netting. Not every IRC has it. But it serves a purpose and removing it creates its own risks. I have never had any issues with the building or the layout and think it works well for its purpose.

25. When I started at Brook House the 60 extra beds had already been introduced so I didn't notice any impact of that change. However, having 3-man rooms (one single

bed and bunk beds) and therefore a 3 man lock up never sat right with me. In my view it was a factor in a lot of arguments between the residents and staff.

26. E-wing served a multitude of purposes. If a resident had a flight or a transfer to HMP the following day they might be accommodated overnight on E-wing. There were medical rooms where residents with medical issues, to include those being weaned off drugs or alcohol, might be accommodated. Spice in particular could turn residents side-ways. If an individual was being bullied (whether that bullying was reported by the victim or witnessed) or a resident was displaying a lack of hygiene or decline in mental or emotional function, they might also be referred to Ewing so that they could be closely monitored. E-wing included 2 constant review rooms where vulnerable residents or residents with safeguarding requirements could be housed so that they could be more closely monitored by staff. If there was a threat to life or limb (for example, because of risk of self-harm or if a resident had already self-harmed) a resident could be placed under constant watch on E-wing. Residents of E-wing were not locked up however and were permitted to come out of their rooms and onto the wing, but they would be shadowed by a staff member. Lock up times for those on E-wing were the same as those for the rest of the centre. There was a higher staff to resident ratio on E-wing. 9/10 times there would be 9 residents and 4 or 5 members of staff. It was much smaller, it was based on one landing and it was much calmer. You didn't get the banging and the racket that you had on the wings. There was one washing machine and dryer for only 9 people. It took the stress off people in my view.

27. To be moved back off E-wing and onto the wings or to come off constant watch the safeguarding threat to a resident would have to have been removed. There would be a formal assessment completed by the duty director and healthcare and involving a multi- disciplinary team. I believe healthcare played a large role in E-wing.

Policies and procedure

28. The Inquiry has not provided me with copies of the policies referred to but I can comment on the listed policies as follows:

a. Home Office Detention Services order on Room Sharing Risk Assessment – I was aware of this. At the time the risk assessment was done by reception when a resident first arrived at the centre. It was part of the process prior to entering the wing. I was not aware of this through any specific training. It was something I became aware of on the job.

b. G4S Gatwick IRC's Incentive Scheme Policy – I was not really aware of this.

c. G4S Detainee Reception and Departures Policy – I was aware of this but didn't use it. I was not trained on it.

d. G4S Gatwick IRC's General Security Risks Policy – I was aware of this through training. This relates to the security and safety of the centre which includes the safety of a cell, how to manage prohibited items, how to do LBBs, how to conduct searches of resident and communal areas. The security of the business is part of our job. It formed part of my initial training and a yearly refresher.

e. Assessment in Care and Detention Teamwork (ACDT) – I was aware of this and used it regularly – a resident gets placed on an ACDT if there is a concern that there is a risk to life or limb. The resident is first assessed based on communication, then a formal ACDT might be opened and depending on the risk might be placed under observation. This formed part of the initial training and was covered in later refresher training. As a DCO I could open an ACDT and put an observation in. Assessment and the care pathway would however be determined by a multi-disciplinary team.

f. Supported Living Plan – I was aware of this and it formed a part of my training. It was there to support people with disabilities or someone with a history of drug use or who was suffering an impairment of any nature and required extra or tailored support or assistance.

g. Minimising and Managing Physical Restraint – I was aware of this policy. It mainly applied to Tinsley House which involved having to work with children.

h. Violence Reduction Strategy – I believe that this started in 2019 and I was never trained in this. There was a department for that specifically. This

department was managed by James Begg. It would be James who compiled documentation and managed this area.

i. Removal from association (Rule 40) care and separation unit policy – I was aware of this policy which formed part of our initial training. This is implemented by managers who can place a resident on rule 40 if their behaviour has been such that they need to be removed from the wing. At the time I wasn't a manager. If the resident's behaviour was that of non-compliance with Centre rules, they may be subject to rule 40 depending of the severity of non-compliance. An example of this would be, demonstrating aggression towards other residents or staff.

j. Age Dispute Policy – I was aware of this and it formed part of my initial training.

k. Detention services Order 03/2015 handling of complaints – I was aware of this and it formed a part of my initial training. Again, it was not used by officers but by managers. All complaints would be investigated.

l. Home Office Detention Services order on Management of Adults at Risk – I was aware of this policy and it formed part of my initial training and subsequent refreshers. However, my training was generic and this was something that I believe was conducted at management level. As a DCO I was not directly involved in it. Assessment encompasses mental, emotional and physical risks and the process assessed the residents' vulnerability status as they are admitted to the centre. There are three levels of risk and the level would be determined by the risk factor based upon the individual's history. That might already be documented if the individual has come from an IRC or HMP environment, or a history would be taken from the individual. If they are reporting abuse that would be documented and reported and escalated appropriately. An adult at risk level 3 could not be kept in detention.

m. Gatwick IRC's Drug and Alcohol strategy – I was aware of this and it formed part of training.

n. Regimes and activities policy – this was not relevant to me in 2017 and I don't recall it forming part of my initial training. It is now central to my role as I am responsible for the activities department.

o. Removal from Association Policy (R40) – this is used if a resident has been non-compliant or violent. They will be placed on Rule 40 (removal from association) and placed in the care and separation unit before they are reassessed by a multi-disciplinary team. They may be segregated because of an assault on another resident or a threat to assault an officer or resident. I was aware of this and it formed part of my training.

p. Detention Services Order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) – I was aware of this policy and it formed a part of my initial training. I didn't personally use this policy as a DCO. It covered the situation where a resident was potentially placed on a Rule 40 but was too violent aggressive and non-complaint. They will therefore first be placed on Rule 42 until the situation has been deescalated to Rule 40.

q. Home Office Detention Services order on care and management of detainees refusing Food and Fluid – I was aware of this and trained in it. I was directly involved as an officer. Attendance at lunch and dinner was closely monitored and if a resident was not eating steps would be taken to ascertain why. If the resident was actually ill, this would be escalated to Oscar 1 who would report to the duty director and management team and would result in an assessment by healthcare. If required, the resident might be placed on E-wing for monitoring.

29. With regard to the policies listed by the Inquiry solicitor at pages 5 and 6 of the Initial Request, I would comment further that there is a difference between the Orders and the Policies to the extent that the Orders set out the requirements and the Policies put the Orders into effect. As an officer my knowledge of the policies came from my on the job experience, not through reading the policies. As far as I am concerned they reflected real life practice at Brook House and provided a good framework for us to work within. I cannot comment on the maintenance and updating of the policies.

Training

30. I believe that I underwent a 6-week training course followed by 2 weeks shadowing. I had no additional training for the role of DCM. It did not prepare you for the role at Brook House and although I don't believe that any training could sufficiently prepare you for the day to day experience, I do think that training could have been improved by making it more relevant to what you are going to experience. It would have been helpful to have a context for what we were learning – for example by giving us a flavour of what it is really like on a wing – allowing us onto the wing to get a feel for the environment and the noise.

31. As I was a DCO at the relevant time, and not a DCM, I cannot comment on any DCM role within the induction process.

32. Whilst I believe that there was an intention that staff should attend annual refreshers I do not recall going on any until last year. However, control & restraint refreshers were mandatory and I was always in date. I did not get any training at the time that was specific to activities officers but I was not an activities officer at the time so am not best placed to comment.

Managerial Training

33. I didn't receive any managerial training when I was promoted to the DCM role. I feel I would have benefited from some training when making the transition – perhaps by being assigned a mentor to show me the ropes. The manager here before me was moved to Tinsley House, so there was no one who knew the job. He also provided no assistance by way of a handover process and there were no other individuals within G4S that I felt I could ask for help. Formal training courses might have helped such as the Chartered Management Institute (CMS) level 3.

34. Due to the lack of a handover, I started from scratch and used my own initiative to work out how to complete tasks. It was extremely difficult at first and this lack of training certainly affected my ability to carry out my role. However, I became more

comfortable in my new role around three months in. I found the transition from DCO to DCM relatively easy, as I felt that I had been supervising the wing before my promotion. I was accustomed to providing residents with advice already, so felt comfortable moving into the new grade. I also had my own office, so I could focus on the additional administration that came with the role.

35. I believe that I asked Juls Williams and DCM Skitt for additional training for the DCM role, but I cannot recall their response. In any event, I did not receive any training.

36. I never raised a complaint or raised concerns about Juls Williams, DCM Skitt or any other manager as at the time, I had no comparison to see how things should be managed. Had a needed to complain, I would have approached senior management. However, I never saw the need and was focused on doing my job to the best of my ability.

37. Overall, I would say that the quality of leadership by managers at Brook House affected my ability to undertake my role as both DCO and DCM, as there was a lack of support. Had I been more supported, I believe that I would have gotten to grips with my roles more quickly. Generally, managers were rarely seen on wings and sat in their offices until requested. My leadership and management style is very different.

38. In my opinion, there was a division between DCOs, DCMs and the SMT. Whilst this did not affect the safety and management of residents, there was a lack of communication and a distinct division.

39. I have considered document VER000238_20. With regard to question 12 on the Further Request, I do not recall which DCMs I was referring to, or what prompted me to say that. Reviewing the document does not assist my memory of this. It is important to note that at the time of my interview with Kate Lampard, I was under the immediate stresses of the role and probably felt aggrieved with the overall

management at Brook House. Therefore, any comments I made will have been based on how I felt at the time in the 'heat of the moment'.

Personal Protection Training

40. Personal Protection training was part of control and restraint training, which included use of force training. The personal protection element of C&R is covered within C&R techniques during the initial training phase. It is not covered in C&R refreshers. Staff who have little to no contact with residents will be trained in personal protection, not C&R. We had C&R refreshers annually as this was required to keep your DCO badge. I thought the content and delivery of training was good and that the training did prepare me for using C&R techniques. Whilst training is different to real life scenarios, I felt confident and safe implementing the training that I had received, for example, during my first use of force incident on D1853.

Role of DCM

41. I have not been provided with a copy of the job description referred to within question 18 (under the sub-heading 'The role of a DCM') in the Initial Request and therefore cannot comment on it.

42. As a DCO I tried to keep the residents motivated and upbeat. I would engage with them as regularly as possible and tried to get to know them and to understand their needs so that I could provide for them sufficiently. That might involve getting them additional clothing or necessary forms and paperwork or providing help and direction. Language could sometimes be a barrier, but we had access to interpreters via Big Word. If the issue was a simple day to day enquiry I might ask a colleague, but 9/10 times I would use Bigword as that way I knew I would get a true and accurate account. Using other detainees as interpreters was not recommended but at times it was useful. As a DCM my approach is not different, although when you are in an activities role as I am now, the residents do in my experience view you somewhat differently from the other DCOs and DCMs. I am here to look after

residents and to do what I can to support them. I have a good relationship with the residents.

43. I am not aware of any incentives to encourage positive behaviour by residents. I cannot comment on the role of the DCM during the ACDT or SLP processes during the relevant period as I was a DCO at the time.

44. Drugs were unfortunately an issue during the relevant period and although there were procedures in place to try and prevent drugs from coming into the Centre, they still entered the Centre most probably through visits. Drug prevention was not part of my role and if drugs were found on visitors the Police would be called and they would handle the situation. That visitor would be banned from further visits. If drugs were found on a resident the resident would be placed on Rule 40 and again the Police would be called.

45. I have considered document VER000238_27 and at question 13 of the Further Response, I have been asked to comment upon the statement that drugs were being brought into Brook House by staff members. This statement was my opinion at the time based upon the restrictions on residents. I do not have any examples or knowledge about this and I was not speaking about a specific person. I was simply generalising and suggesting that this was a possibility.

Managerial Oversight

46. I was not aware of any racist, homophobic and/or misogynistic attitudes or behaviours amongst staff, or of specific staff bringing drugs into Brook House. I did not experience any bullying by any other staff at Brook House and I did not have any concerns about other staff being bullied. Neither did I ever have to deal with a staff complaint about bullying.

Relationship with the Home Office

47. In my experience the Home Office were very professional at all times. I had very little contact with them in 2017 – my contact was only with the engagement team. Removal directions were given via the visits hall. I perceived no issues with the balancing of immigration removal procedures with the welfare of residents.

Relationship with Senior Managers

48. As a DCO I had no engagement with the SMT – I didn't even know that there was a senior management team. I never knew who my direct line manager was, and the residential manager was very rarely seen. The managers tended to be based in their offices. Whilst you could contact them you would not generally see them about the Centre. I believe that this was because they were extremely stretched - sometimes one manager had to run 5 wings. I cannot comment on the quality of leadership as I had very little, if any, contact with the leadership team.

Relationship with Junior staff

49. I was a DCO myself at the relevant time and cannot comment upon the training needs of junior staff.

Relationships with other DCMs

50. I was not a DCM during the relevant period and am unable to comment upon the management committee system.

Relationship with Healthcare

51. I had very little contact with healthcare in 2017 as a DCO unless they came onto the wing to administer paracetamol. I never had the need to refer anyone to them during that period as far as I recall.

52. I have considered document VER000238_28. In my opinion, healthcare provided a basic evaluation of residents and often showed a lack of compassion. I felt that healthcare assumed that paracetamol was the key to every illness. Healthcare would provide paracetamol to DCOs, who would be responsible for administering it to residents. This would be logged to monitor usage.

53. As far as I am concerned, healthcare played an effective part in Use of Force Incidents which I was involved in from time to time. They were responsive to both spontaneous and planned use of force incidents and would accompany the team when they could. I was not involved in communications with them about residents' on-going medical needs and I am unable to comment upon the attitude of healthcare staff to any specific individuals aside from I recall one example where a member of healthcare once asked me to send up a resident to healthcare for his medication. The resident had a case on as he had broken his leg and he was not able to walk up the stairs. I explained this to healthcare who seemed uninterested and said that if he did not make his way up in the next 5 minutes, he would miss his medication slot. I do not recall the name of the healthcare nurse at the time, but they refused to come down to meet the resident. They said to just prescribe paracetamol as he was in pain.

Disciplinary and Grievance Process

54. I was not involved in any disciplinary investigations into my own conduct or the conduct of another member of staff during the relevant period.

55. It was however quite common for there to be a referral to PSU (an external auditing company) following use of force incidents. However, PSU never raised any issues with me or took any action against me following an incident.

Staffing levels

56. As per my earlier comments, in my view we were significantly understaffed and the inadequate staffing made it difficult for us to fulfil our roles adequately, as we did not have the time to spend with the residents in order to properly assess or meet their needs. I also felt that the understaffing placed staff at risk. I did not formally raise any concerns as I did not have any confidence that matters would be addressed. The prevailing attitude amongst staff was simply that those were the conditions we operated in and we needed to make the best of it.

57. I did not have any input into the staffing plans pre or post September 2017, although post September 2017 I am aware that staffing levels were increased. An E1 grade of management was introduced and I was asked to apply for the role of DCM responsible for activities and the cleanliness and maintenance of the centre and contributing to violence reduction. However staffing levels still remained low. Following Panorama, people didn't want to be here and we lost some valuable staff members because they did not get the promotion that they wanted. With them we also lost experience and knowledge.

58. Understaffing meant that we had to prioritise the most vulnerable. We could only try and do what we could. This caused frustration for both staff and detainees and put massive strain on everyone including healthcare as we would sometimes send to healthcare issues that otherwise we might have been able to deal with ourselves. Understaffing also impacted on activities as there were not enough activities staff to provide a wide range of activities. As far as I can recall the IT room and library were the only things that had activity staff. Back then I didn't even know that there was an activities team.

59. As a consequence, everyone was over stretched and morale was low as we were not providing the service we would have liked to. This also had an impact on safety and increased vulnerability of staff and residents.

60. I cannot comment upon the staffing levels of the healthcare team.

Recruitment

61. I was not involved in staff recruitment at Brook House and cannot comment further on this. However, I believe it was difficult to recruit staff particularly after Panorama aired. The package offered was not attractive and therefore did not attract good and experienced candidates.

Retention

62. I don't believe that anything within the recruitment process itself would have had a positive impact upon retention rates although as I have said previously a clearer understanding of the environment and a context for the training would have better prepared us for the reality of working at Brook House. However, a better salary and initiatives such as courses and certifications might have improved retention rates.

63. I don't believe that the new shifts had an impact on staff retention, but it had an effect on morale although it didn't make much of a difference to me as I live quite nearby. For those with longer commutes however, it made a long shift even longer and the working day could therefore be gruelling.

Tinsley House Staff

64. In my view Tinsley House staff were extremely valuable. When Tinsley House was being renovated the majority of staff were cross-deployed to Brook House leaving only a skeleton staff at Tinsley House and this alleviated some of the staffing pressure at Brook House for a short period. By the time I got my clearance however, the Tinsley House staff had already gone back to Tinsley House. However, they were invaluable whilst they were here as they allowed the Brook House staff to do the stuff that needed to be done. The job and the policies were essentially the same, but the processes and the environment were different. The difference in environment did cause some difficulties for Tinsley House staff and

I believe that some of them were uncomfortable with the environment, but they were able to do the job and at the very least to support the Brook House staff.

Treatment of Individuals

65. I did not work on reception and cannot comment upon the process there. I have not been sent a copy of the induction policy that the Inquiry solicitors refer to at question 56 of the Initial Request, and in any event I did not work on reception or the induction wing.

Activities for Individuals

66. As I have stated above, at the time I did not know that there was an activities team and neither was I familiar with any detail of the activities programme. I knew there was a pool table and table tennis table and a courtyard. I did not have an opinion on the programme as I did not have anything to compare it with. Now, in hindsight, given my current role in activities I think that the lack of activities may have exacerbated issues within the Centre during the relevant period because of the engagement of residents in activities and the way in which I now believe activities can de-escalate a situation. If there is something bubbling if we can run an activity, send activities guys down to engage with residents that sometimes diffuses tensions. Activities encourage residents to be active and de-escalates situations.

67. Now there is a full activities programme. We have a gym, gym equipment on wings, personal training, 2 IT suites, 2 education suites, arts and crafts, kindles, air-hockey, pool tables, table tennis tables, X box, play-stations, 4 courtyards, outside football goals, basketball nets and balls, badminton posts and rackets, cricket, arts and crafts competitions, outside exercise equipment, nutritional information, circuit exercises, organised sports, board games etc. Our staff can gain qualifications and we are constantly striving to improve our offering to residents.

Immigration Rule 35 Process

68. During the relevant period I was a DCO and DCOs were not involved in the rule 35 process. This involves victims of torture and was primarily lead by healthcare. I therefore cannot comment on the process and speed of the process or any delays at the time.

Use of Force

69. I was involved in Use of Force incidents quite frequently. The residents at the time were boisterous and the numbers high. We were pretty much maxed out in terms of capacity. 508 was the capacity and at that time we were never far off full capacity. The wings were full. Little things could cause friction and it could be quite a nasty place to be on occasions. A lot more removal directions were being issued at the time as well and therefore residents were often being given unwelcome news. When residents did not want to return to their country of origin it could cause tension and outbursts. In those circumstances there might have to be a planned intervention if, for example, the resident then refused to go. The residents in our care now are somewhat different from previously. Due to the high volume of staff to residents, it is better managed, therefore residents do not feel like they are under supported and this creates a better living environment with less animosity.

70. I can't remember specifics of any particular incident but after an incident we had to complete paperwork in order to compile and submit a use of force report. All of those directly involved or direct witnesses had to complete a report and the supervisor would also complete a report which could take up to 4 hours. This also had an impact on available staffing levels as staff involved in the incident were away from their normal duties completing the report. Each individual's report was consolidated, put into one file and sent into the Chaplaincy, this being one of many agencies that had to be notified. There was also the IMB, Security, Duty Director and the Home Office who had to be sent a copy. In an average week at that time we probably used force 5 or 6 times. Every incident was different – never any two the same. There was an attempt to extrapolate lessons and a debriefing would be held after each incident.

71. I had no concerns about any incidents. The first port of call is always de-escalation and when force was used it was because de-escalation had failed. During the relevant period de-escalation was much more difficult because of the number and type of residents accommodated at Brook House. Many of the detainees were ex HMP and this led to a boisterous environment full of alpha males who did not want to back down in an escalating situation. Nevertheless, we deployed all de-escalation techniques at our disposal. We would use communication to try and de-escalate and for example, if the resident was in a paid activity, we would get the relevant activity officer to speak to them or if there was an officer who had a particular rapport with a resident, we would engage them in the communications. The objective being to achieve the desired outcome through communication and negotiation. Force was the last resort and could often not be avoided, but I always felt that the force used was reasonable, proportionate and necessary. No more than necessary force was used. I believe that Control & Restraint works and is necessary for the safety of the officer and the safety, welfare and protection of other residents.

Individual Welfare

72. I did not receive any specific training in relation to individual welfare or mental health during the relevant period. We were put on a mental health awareness course, but I believe that this was post Panorama.

73. As an officer if I became concerned about the mental health of a resident, I would refer them for a mental health assessment. We had mental health services on site, and I would make the necessary referral. I might, for example, make a referral if: a resident's characteristics had changed, or they seemed depressed, or were talking about emotional connections, or stopped eating, or were isolating in their room, if their personal hygiene had deteriorated, or their room was a mess when it wouldn't usually be, or if they were sleeping all the time and their lights were out and curtains drawn. Depending on the severity of our concerns I would try and talk to them myself, go in sit down take a seat, provide common ground, ask how things were, whether there was a reason for their behaviour (for example if they weren't

eating) to try and get to the root of the problem. Whilst doing so I would look for ligatures etc. In this line of business you have to be on the ball. Where necessary I would make a referral. The referral form required detail on the mood of the resident and why we feel that they need to see the mental health nurse. I didn't have to make a referral very often. That would be the totality of our involvement. Healthcare would then take over – a mental health nurse would book an appointment normally within 48 hours. I knew the process through experienced officers who showed me. I did not have any issues with the sufficiency and availability of the healthcare team for individuals with mental health needs.

74. There were some issues with drugs entering Brook House at the relevant time. However, Visits was not my domain and therefore I cannot comment in any detail on the policies that were in place at the time. However, they did not succeed in eliminating the problem. Different people have different tolerance levels to drugs, but the effects were similar. They induced fits, vomiting, zombie like demeanour, withdrawal. Hooch, spice and cannabis were used by residents. Hooch could often lead to aggression and uncontrollable verbal abuse and led to violence.

75. I believe that drug rehabilitation may have been provided by the Forward Trust who dealt with drug rehabilitation and alcohol abuse. They gave out leaflets to residents and there was a resident spokesperson who had undergone training. They were external to G4S but worked on site and were permanently there. We could refer a resident to them but they also had an open door policy and therefore were readily available to residents. Referrals would be made either through security, healthcare or us.

76. As far as I am aware, Chaplaincy never raised a concern about individual welfare.

77. The process when an individual self-harmed would depend on the severity of the incident. If they self-harmed but with no risk to life, healthcare would provide the necessary medical care and an ACDT would be opened and the resident placed on E-wing for 24 hours. There would be a case review through a multi-disciplinary and a plan put in place. If there was a risk to life an ambulance would be called

and officers would accompany the resident to hospital. They would be placed under constant watch. Once in hospital, a duty director would visit. Staff would remain at the hospital with the resident until they were ready to come back. On their return, they would be placed under constant watch on E-wing. Their care would be overseen by healthcare.

78. I have described the process followed when a resident refused food at paragraph The Inquiry has not provided me with copies of the policies referred to but I can comment on the listed policies as follows: of my statement. I believe that the process was sufficient and fulfilled its purpose.

Individuals as time served TSFNO (Time Served Foreign National offenders)

79. I didn't work on reception so cannot comment upon the reception process.

80. I adopted the same approach to TSFNOs as I did to non TSFNO residents. The co-location of TSFNOs with non TSFNOs caused some difficulties insofar as TSFNOs were used to a prison style environment and could be assertive and challenging and this was sometimes unsettling for non TSFNOs. There was a high proportion of TSFNOs at Brook House at the time (2017/2018).

Abuse of Individuals

81. I did not have any concerns about the abuse of residents by staff whilst working at Brook House.

82. There were sometimes assaults by residents on other residents and sometimes that might involve a group or groups of residents. Sometimes, if a situation could not be diffused it was necessary to call the First Response team to manage a situation, which might involve control and restraint. Their response was always quick and efficient and I was always happy with the way that they responded and the degree of force employed to take control of a situation.

Complaints

83. There was a complaints process that residents could follow if they had any complaints or concerns. There were complaints forms in multiple languages available throughout the Centre and in my experience, residents fully understood how to make a complaint. Often their first port of call might be to speak to a staff member and this might be sufficient to resolve issues. However, if they completed a complaints form, the form would be placed in a box for review and the complaint would be referred and reviewed by the Home Office who would then liaise with the complaints team as appropriate. The complaints team in turn would liaise with the department manager. I didn't personally deal with complaints as an officer as it was not in my remit. If the complaint raised any safeguarding concerns, any immediate necessary action would be taken, for example, the opening of anti-bullying logs, separation of residents, or the opening of an ACDT.

84. Residents could also contact the IMB and the phone number was available to them. If the complaint was sufficiently serious (for example, a complaint about use of force) the PSU would investigate. Most officers have been subject to an investigation by PSU at one time or another arising from a use of force incident, this is normal process if a resident formalises a complaint about the force which was used against them and the resident felt it was not in line with guidelines. I do not recall being involved in a PSU investigation at the relevant time, though I have been involved in PSU investigations. I have always found the investigations to be very thorough and the outcome of the investigations have always been supportive of my part in any incident.

85. The processes are always nerve-wracking, but I understand and accept the need for them and feel that they are effective.

86. The complaints procedure for residents wanting to make complaints about any other matters such as healthcare is identical to the procedure that I have described at paragraph 83.

The Panorama Programme

87. I watched the Panorama documentary on Brook House around the time that it aired. I was on duty when they aired it and experienced the reaction from the residents. The residents were watching it in their rooms and some of them began shouting, kicking and banging on the doors, and being abusive, loud and aggressive. I was by myself on Dove wing and it was quite intimidating partly because we were uncertain as to what would happen when we opened the doors the next morning. The people implicated in the documentary no longer worked at Brook House, but the residents didn't know that. It was a challenging couple of days. There was no communication from management. The next day extra staff were called in from Tinsley House and the Nationals (National Tactical Response Group) were on standby at Tinsley House in case there was trouble.

88. Those implicated disappeared - one minute they were there and the next they weren't. There was a lot of speculation but we didn't know what was going on. We went from short staffed to extremely short staffed.

89. I did not work with Callum Tully and do not appear in the Panorama documentary.

90. Panorama had an extremely negative impact on morale. The events depicted in the programme came as a massive shock to the majority of staff who had not witnessed or been aware of the behaviours captured. There was a sense of shame and of all staff being tarred with the same brush in the eyes of the residents and the public, and of our reputation being tarnished. Staff were embarrassed to say that they worked at Brook House. There was also a sense that the programme did not reflect any of the good and hard work carried out by the staff. This led to some staff members leaving which compounded the staffing issues. New residents were also apprehensive about being admitted to Brook House in the wake of the programme and that was disturbing and disheartening. The programme also put staff on edge. There was a feeling that no-one was to be trusted and also a concern for personal security and that staff could become a target for reprisals. Morale was rock bottom.

91. However, the programme did signal some positive change in the longer term. There were in my view changes that had to be made – more managers and staff. As I recall, the Kate Lampard report highlighted a few issues such as the need for a stepping stone between DCM and Senior Management and this resulted in the creation of the E1 grade. Policies were also reviewed and changed and security was adjusted. I thought that G4S tried hard to address the issues.

92. Despite our fears, nothing kicked off the following day. The residents came out of their rooms for breakfast and carried on as normal. Bar a few comments and the erection of a few pictures of Callum Tulley around the wing (which in the event was managed by another resident who asked that the pictures be taken down) the residents responded well. The residents that were here knew the staff that they worked with and were able to distinguish them from those captured by Panorama and chose not to abuse the remaining staff who had not engaged in those behaviours. I felt that the residents treated staff with respect and dignity. The violence and abuse that we had expected didn't come. They understood that the footage had been taken some time before it was aired, that those implicated no longer worked at Brook House and that those involved were in the minority. To my knowledge they never took it out on anyone. I was very, very surprised as an adverse reaction would have been understandable.

93. I was not aware of any of the behaviours displayed during the Panorama programme. As set out above, they shocked me and other staff members. Had I been aware of such behaviour, I would have raised it and escalated it with the appropriate senior management.

94. I was never involved in age dispute and wouldn't have known that there was an age dispute policy. If I was told or suspected that a resident was under age that would have raised a flag with me however and I would have sought guidance.

95. As I have said previously, following Panorama staffing was increased as was management involvement and policies and procedures were reviewed and revised. I felt that the changes were effective.

Specific Individuals

96. At question 89 of the Initial Request, the Inquiry solicitor sets out a list of the names of individuals who it says were either investigated, disciplined, dismissed or left. I cannot be confident of the accuracy of that statement but comment as follows:

a) Nathan Ring – I didn't know him.

b) Steve Webb – was a residential manager here. I only saw him when he came onto the wing to resolve an issue. I have no idea what he was like.

c) Chris Donnelly – still works here – I vaguely remember him as an Oscar 1 and they didn't really come onto the wings. I found him to be professional and had no concerns about him.

d) Kalvin Sanders – I worked with a couple of times. It is hard to give a professional opinion on him. I felt he was a bit of a chameleon and said what he felt he needed to say to fit in. In my opinion it is unlikely that what he said happened in Panorama actually happened. He talks of banging someone's head against a window, I don't think that he would have been capable of that. He was not in my experience a violent guy or built for violence.

e) Derek Murphy – was a residential manager. I saw him a couple of times on the wing and never saw anything unprofessional.

f) John Connolly – was a C&R instructor. He was always professional and I never saw him displaying any of the behaviours depicted in Panorama. I was surprised and shocked by what I saw.

g) Dave Webb – was also a C&R instructor and I would make the same observations of him as I did of John Connolly.

h) Clayton Fraser – I didn't know.

i) Charles Frances - worked on E-wing as an officer. I can't remember him being in Panorama. He was like everybody's grandad - he listened to problems, was very laid back and had time for everybody. He was not at all violent.

j) Aaron Stokes – I don't recall.

k) Mark Earl – I don't recall.

l) Slim Bassoud – still works here – in welfare. I didn't know him as an officer but he is a good lad and entirely professional.

m) Sean Sayers – I didn't know.

n) Ryan Bromley – works in my department. I worked with him a couple of times on E-wing. He is one of the best officers in my opinion. He is well liked and well respected and is not a violent person at all.

o) Daniel Small – I don't know.

p) Yan Paschali – I cannot comment on him, as I did not know him at the time.

q) Daniel Lake – I don't know.

r) Babatunde Fagbo – I didn't work with.

s) Shayne Munro – I don't know.

t) Jo Buss – I don't know.

I did not witness any of the above using derogatory or offensive language or making insensitive remarks. Neither have I witnessed any of them engaging in verbal or physical abuse.

Suggestions for Improvement

97. I have nothing further to add to the statement that I have made with regard to the treatment of residents or the health, safety and welfare of staff and residents at Brook House during the relevant period.

Any Other Concerns

98. I am unable to identify any specific individuals that may have the requisite knowledge to assist the Inquiry.

Additional Responses to the Further Request

99. I set out below my response to any questions contained within the Further Request that have not been addressed above.

Incident on 12 August 2017

100. The reference to 'DCM 02' in document HOM002747 appears to be a reference to me. However, I was a DCO at the time of the incident on 12 August 2017, so this is an error.

101. The incident on 12 August 2017 occurred due to two individuals throwing a latex glove filled with water onto the suicide netting below, causing it to burst over a number of residents. I recall that I was in the office at the time and that this was during the latter stages of the lunch service. I requested a manager to attend the scene, but I was the only person in the office to deal with the issue. I could see that the situation was escalating, so I called the two perpetrators into the office to discuss the incident. Around this time, three managers appeared and they allowed me to challenge the perpetrators to establish what had occurred. I recall that I had asked whether I could review the CCTV footage relating to the incident, which was usually a task reserved for more senior staff, but this request was rejected by the Oscar 1. I do not recall who this was at the time, but it may have been Steve Dix.

102. After questioning the two individuals, I left any further decision making to the three managers. I had deescalated the situation, located the perpetrators and found out what had occurred. Both residents were apologetic, but it was important for me to remove them from the scene as those impacted by the water were becoming

increasingly irate. I had kept the situation calm and 'low-key' to avoid further escalation and then reported it to the three managers (as well as my line manager) when they arrived on scene. I recall that one of the managers present, Derek Murphy, complimented me on how I handled the situation, commenting that he could see me as a DCM. I do not recall which other managers were present.

Training

103. I have considered document VER000238_9. With regard to question 5 on the Further Request, I had not attended an MMPR refresher in the previous six months, as it was not a requirement for my role. MMPR training focuses on use of force against children and is only required for those who work at Tinsley House. Brook House only house adult males, so it would not have been necessary for me to complete this training. I do not consider that it would have been useful to complete this training prior to the use of force against D1853, as it was not relevant to my role.

104. I have considered document HOM002548. With regard to question 7 on the Further Request, this comment appears to have been taken out of context following my conversation with Kate Lampard. I did not mean that I never received training as a DCO, more that the training that I did receive was very theory based and did not prepare you for the environment and atmosphere at Brook House. Prior to starting, I had no introduction to the wings and would have benefited from a mentor and some practical training, for example, a walk around. As far as I recall, I did not ask for any additional training as a DCO (over and above the six week initial training course) as I believed that this initial training was all we would be provided with / required.

Staffing Levels

105. I have considered document CJS005648. In response to question 16 on the Further Request, this was an incident involving 20 – 25 residents fighting. The incident started on the C wing courtyard and I believe that it occurred due to a divide in

cultures that had been escalating for some time. The incident filtered onto D wing before being deescalated by staff. We had good staffing levels on that day, so it was dealt with quite quickly. I did not have to use force during the incident.

Use of Force

106. In relation to the use of force against D1853 on 15 June 2017, I was the 3rd officer (the arm officer) and took control of the resident's left arm during the restraint. This was my first use of force. The resident was initially compliant, but then became non-compliant after exiting his room. It is my honest belief that the force used was proportionate, reasonable and necessary. From my perspective, nothing that I did was excessive or unreasonable in the circumstances.

107. I do not recall whether I had any concerns about other staff involved in the incident. Tascor are responsible for transporting residents from Brook House to other IRCs or flights. My recollection is that they handled this use of force incident well.

108. My statement does not mention that D1853 complained when placed in a final lock as in my experience, everyone who is placed into a final lock complains. Final locks are designed to be slightly uncomfortable, so it is not unusual for a resident to complain. At that time, I do not recall hearing D1853 complain, but had I heard significant complaints, I would have adjusted my lock and written it down in my report following the incident.

109. I am unable to respond to question 18c on the Further Request, as I was not debriefed about stair manoeuvres and I cannot recall this. This was my first C&R, so I can only imagine that there were learning issues, but I do not recall these being highlighted at the time. The incident was not highlighted to me during refresher training.

110. I do not recall whether healthcare were present during the use of force against D1853. As this particular incident was my first use of force, I would not have known whether healthcare would have been expected to attend.

111. The relationship between officers and healthcare during use of force incidents was amicable. Healthcare were expected to be present on a planned use of force to inform the team of any injuries that the resident may have prior to using C&R techniques. They would also assess the resident afterwards. For example, if they knew that a resident had a fractured wrist, they would say be cautious around that area.

Complaints

112. With regard to complaints, a resident would fill in a complaints form and post it into the Home Office box. It would be picked up the following day by the Home Office and cascaded to residential senior managers to pass on to the DCM's. It would have to be investigated by the DCM within 28 days and approved by the complaints and audit team. The letter would then be forwarded on to the resident with the outcome.

113. With regard to question 21 in the Further Request, I was not aware of the process at the time as I was a DCO and relatively new to the role. Notwithstanding this, for the reasons set out above, I did not consider that this incident fell within the typical complaint category. At the time, my impression was that residents involved in this incident would not have wanted to lodge a formal complaint in the usual manner (filling out forms etc.), but would rather immediate action was taken. Had I offered the residents impacted by the water the option of filling in a complaint form, I expect that they would have been angered by my response. The formal complaints procedure did not appear applicable in that particular scenario.

114. I was not involved in the complaints procedure for this matter. As set out above, I had informed my line manager about the incident and had done everything within my power to deescalate and manage the situation. As far as I was concerned, I had done everything that was expected of me as a DCO and any further action would be taken by more senior staff.

115. I have considered HOM002747. In order to view CCTV footage, a DCM would need to complete a form. I do not know which forms / documents needed to be completed. I was a DCO at the time of the incident on 12 August 2017 and did not have authorisation to view the footage. I do not know which manager ultimately viewed the footage.

116. With regard to question 25 contained within the Further Request, I was new to the role at the time of the incident and for the reasons set out above, I was under the impression that other managers were dealing with the incident. This is what I was told by the Oscar 1. I was not instructed to fill in any documentation related to the incident. Please note, SIR stands for Security Information Report, not Serious Incident Report. I do not know why the managers did not fill in any of these documents.

117. I have considered document HOM002548_1. I cannot comment on whether it was common practice not to fill in the requisite forms when officers received a complaint. I am unable to comment on what others did. However, I was not aware of and did not partake in any deliberate concealment of incidents and I was never party to any discussions where people agreed not to record events. From my perspective, as I gained knowledge and experience throughout my time at Brook House, I became more accustomed to the correct documentation to fill in and when.

118. I have considered document HOM2748_29-30. With regard to question 27 of the Further Request, I cannot comment on these matters as it was not my decision and I was not part of the decision making process. I was a DCO, not a DCM. With regard to protection, I felt that I had successfully deescalated the situation such that there was little risk of any further action being taken by the perpetrators. If anything, my main concern was for the perpetrators who could have faced reprisals for their actions. That is why I was so cautious in keeping my initial investigation low-key and taking the perpetrators away from the scene. In my opinion, I effectively challenged the perpetrators for their behaviour. I can only assume that the DCMs were happy and satisfied at the time that the incident had been well

handled and deescalated, such that it was not deemed necessary to pursue a rule 40. This is an assumption based on the outcome.

119. I have considered document CJS000895 Tab BH IR Log Row 129. I was honest with the PSU throughout their investigation and they were satisfied with my answers. There is no question that this incident occurred, which is probably why the outcome was 'substantiated'. However, I was not in a position at the time to escalate the matter and was under the impression that the DCMs present were handling it with integrity. I had no reason to doubt that at the time. In hindsight, with the knowledge I know now, I would have placed both residents on rule 40.

Individual Welfare

120. In relation to question 29 of the Further Request, having reviewed the documentation I still do not recall this incident.

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	Ryan Harkness
Signature	**Signature**
Date	11/02/2022