BROOK HOUSE INQUIRY

First Witness Statement of Megan Cunningham

I provide this statement in response to two requests under Rule 9 of the Inquiry Rules 2006 dated 30 June 2021 and 3 November 2021.

I, Megan Cunningham, of c/o Serco, Enterprise House, 11 Bartley Wood Business Park, Bartley Way, Hook, Hampshire, RG27 9XB, will say as follows:

Introduction

1. I have been working since the age of 16 in many different jobs to include retail and working in pubs. I have a degree in criminology and psychology, which I obtained in around 2015/16 and after my degree went straight to working at Gatwick IRC for G4S.

Background:

2. I am a DCO currently employed by Serco at Brook House Gatwick IRC. During the relevant period I was employed by G4S first as an Assistant Custody Officer from May 2016 to October 2016 and then as a Detention Custody Officer from October 2016. My role as an Assistant Custody Officer was a public facing role in which I was front of house at the gatehouse visit centre and had no face-to-face contact with detainees. Prior to commencing my role as a Detention Custody Officer in October 2016 I underwent a 6-week training course. I worked in detainee reception and discharge up until August 2019. In July 2019, I moved to the security department where I currently work.
3. Having considered the job description at CJS004294, I can confirm that this was the role I carried out at Brook House during the relevant period.
4. During my time working at Gatwick, I have become an ACDT assessor, undergone Control and Restraint training with yearly refreshers and because of

~~my position in Security I have completed an intelligence foundation course and~~ intelligence analyst part 1. I am still employed by Serco in the Security Department at Gatwick IRC but am currently on maternity leave.

Culture

5. The culture at Brook House during the relevant period was good. Everyone worked well together, looked after each other and everyone was happy. I felt safe.

6. Tinsley House was shut at the time I think, and the level of staffing was better than it had been before. However, for me morale was always good, and I didn't think morale took a particular hit when the staff went back to Tinsley. Our department always had 4 staff rostered on and staffing levels very rarely dropped. If they did, we dropped to 2 but we worked together to make it work.

7. I never saw anything untoward at Brook House. Because I worked in reception, we were the first point of call. We had to ask sensitive questions about self-harm etc, so we were very invested in what the detainees were saying. We strived to be sensitive and empathetic at all times.

8. I had no concerns about how the values of G4S or its culture impacted on the general protection of the detainees, the management of staff or the protection of especially vulnerable individuals. I didn't see any of the behaviours depicted in the Panorama documentary and I was shocked by what I saw. It is hard to comprehend.

9. I had no issues with SMT or management in general. I was managed by a DCM. I always found DCMs to be accessible. There is an Oscar 2 office in the reception area and Oscar 2 would always be there unless an incident occurred which they would attend. The Oscar 2 office was close to where we were, and we would always get a quick and easy response from them. Our Senior Manager also always came to see us in the morning and every now and then during the day to check on us. Management was visible and accessible.

10. I am not aware of any occasions on which anyone raised concerns about the treatment of detained persons either informally or as a whistle-blower.

Policies and Procedures

11. I don't recall my attention being brought to specific policies during the relevant period, but procedures were drawn to our attention at the beginning of employment. When I walked into my role, I was taught the job as I went along. It was on the job training. In my view the procedures reflected policy, but we didn't necessarily read the policies themselves. By the end I knew my job in and out. We would look up what was expected of us.

12. Working in Reception the main policy was the Detention Service Order (DSO) and in Security it is the SIS (Security Information System). DSOs can be found on the government website. We were also encouraged to read PSO 1600 for Control and Restraint. In my opinion the procedures took into account the realities of Brook House. I cannot comment upon whether the policies were properly maintained and updated.

13. I worked in the reception area therefore the induction policy (CJS006042) did not fall within my job remit. As is stated at page 4 of CJS006042, induction begins as soon as the reception process is completed.

Booking in process

14. On reception, one of my roles was to deal with the process of booking in of detainees.

15. The length of time that this process would take would vary on a number of factors, such as where the detainee was coming from, language barriers, staffing and luggage/possessions. For example, a detainee who had arrived to the UK by boat might only have one bag and there would be very little information about their background and so it was usually quicker to process those individuals than someone who had arrived from a property with a lot of baggage.

16. The target for completing this process was three hours. It took an average of 45 minutes to one hour to book an individual in but then they would have to go through a health care assessment.

17. If a major incident was happening at the centre, then we might have to stop movements in the centre and we would have to wait before continuing with the booking in process.

18. During the booking in process, we would have a conversation with the detainee about their personal circumstances and then they would be shown to a waiting room where they were offered food and have access to books and a television until they were seen by healthcare and allocated a room. There was usually a group of approximately 6 to 10 people in the waiting room at any one time.

19. Once detainees had been booked in, they were offered a phone call to call a relative or loved one. They were also provided with a mobile phone with a sim card although this did not have credit so we would suggest that they make an initial call to leave their new contact number with those they wished to contact them. If they arrived with money, we would offer £5 top up that they could purchase in reception.

20. The process for departures was that detainees would come to discharge at a specified time when Tascor were due to collect the detainees and their belongings.

Risk assessment process for room sharing

21. If we were missing some information relating to a detainee, this would make it difficult to assess an individual. If key information were missing, the detainee would be allocated a single occupancy room until we obtained the relevant information.

22. If a detainee came from prison, I would expect to see the offence(s) committed detailed on their movement order. If there was no offence recorded then I would question it and chase the relevant information.

23. For detainees who had just entered the UK, we would not have any information so we would rely on talking to them to find out their history.

24. The risk assessment was not just done on the documentation we had, we would also speak with individuals to learn more about them. For example, I would ask how they felt being put into a room with someone of a different nationality. If they made racist comments then I would make sure they were not put in a room with anyone of a different nationality.

Training

25. I underwent a 6-week training course in May 2016 and October 2016. The course was 6 weeks followed by shadowing for 2 weeks. I can't recall whether there was any formal shadowing when I became an assistant Custody Officer, but I assume so as I had to watch and learn in order to do the job. However, I shadowed a colleague when I became a DCO. The training was delivered at Brook House, but I can no longer remember what was covered in it.

26. I felt that the training was good as a basis but it didn't prepare you for going live. The shadowing helped but I think it should be longer than 2 weeks. We were issued with a tick sheet which allowed us to tick off all areas covered in training and you could request further assistance if there were any areas that needed further training. This was completed by me and by the person I was shadowing. It was a broad booklet so half of the areas listed were not relevant because they were aimed at wing staff. I made sure I knew my department inside and out.

The role of a DCO

27. I always treated detainees with respect. Naturally, there were language barriers to overcome but we had facilities such as Big Word. You could use staff, but I didn't tend to do that as pulling someone down from their duties to translate could cause difficulties. I was also reluctant to use other detainees because of

the potential sensitivity of information being conveyed, and also the risk of not capturing the detail of what was said.

28. The only incentive for detainees to encourage positive behaviour that I can think of was paid work. They had to apply for it and, if they met the criteria, they would get the position. I don't know what the criteria was. There wasn't much of a deterrent for negative behaviour other than the care and separation unit as I believe this could result in having the job revoked. I don't believe that the detainees had to behave well to get the job in the first place although I believe that if they had spent time in the care and separation unit they had to be out of rule 40 for a month.

29. The role of the DCO during the ACDT process was to open an ACDT, raise concerns to managers, carry out observations and assess individuals. Any kind of concern about individual welfare could be raised via an ACDT, for example low mood or self-harm. Initially if you had concerns you would talk to the individual to see how they were feeling and whether they had any problems or issues but if your concerns continued an ACDT would be opened. The DCO would then inform their manager who would inform the assessor.

30. There were processes in place to prevent drugs from entering Brook House. All items were x-rayed and searched when coming into centre. All visitors were searched. The security department would conduct an analysis on people who were having daily visits to build any relevant picture. However, despite those processes not all drugs were found as not all show up. Staff were also subject to sporadic searches. I was searched when I started in May 2016 and again in 2018. If drugs were found on visitors or staff the Police would be called. Visitors bringing in drugs would be banned, and any staff implicated in bringing in drugs would be suspended and dismissed.

31. I did not work as one of the welfare team and cannot comment on that team.

32. I was not part of the security team during the relevant period so cannot comment on the process for processing TSFNOs during the Relevant period.

Relationship with Staff

33. I did not experience any racist, homophobic, or misogynistic attitudes amongst staff during the relevant period. Neither did I experience any bullying or have any concerns about other staff being bullied or have to deal with a staff complaint about bullying.

Relationship with Home Office

34. I had minimal contact with Home Office and only came into contact with them when confirming releases and completing requests. This ran smoothly and I had no issues. I don't feel equipped to comment on how they balanced immigration removal procedures with individual welfare.

Relationship with Senior Managers

35. My relationship with Senior Managers was good. I had daily contact and felt that there was good visibility of senior management as I have commented previously.

36. I had no issues with the quality of leadership.

Relationship with DCMs

37. My relationship with DCMs was good and I had no issues. I was managed by a DCM, although I can't remember which one. I recall having 1-2-1s and a yearly appraisal type meeting at which there would be a performance/competency review. It focused upon how you were getting on, how you were doing, and your aspirations. It was a bit of a tick box exercise at the time and I think they are done better now. I was proactive in my approach to appraisals so would make sure that I got what I needed to get out of it. For example, I wanted to become an ACDT assessor and shadow the Safer Community department and I did that. I wanted to push myself to learn things I wouldn't ordinarily get the opportunity to learn.

38. I thought that the quality of management by DCMs at Brook House was good.

Relationships with Other DCOs

39. I felt confident that I could rely upon other DCOs – we were a strong team. There were generally 4 DCOs rostered on duty within reception. I had an excellent relationship with all of them and it didn't matter who I was rostered with. There were 20 individual people in the department of varying ages, and we were all there to help each other. At busy times we worked together and got on with it. It was a supportive and friendly environment.

Relationships with Healthcare Staff

40. It was a difficult time within healthcare during the relevant time and it felt like we were fighting a constant battle due to them not seeing admissions within two-hour time frames and all going on lunch at the same time. Because of the difficulties we had to get our Oscars involved. Healthcare was understaffed and they were run off their feet. They probably did the best they could but from a reception perspective it was difficult. Part of our policy and contractual requirements was that admissions had to be processed within 3 hours and healthcare had to see them and assess them within 2 hours of arrival in the centre. There were penalty points for healthcare if they didn't. Everyone had to be seen and assessed by them. I can't comment upon their involvement in use of force events as I had very minimal involvement in use of force. I can't remember any communications with healthcare about individuals with on-going medical needs and I cannot comment upon the attitude of healthcare staff towards detainees.

Disciplinary and Grievance Process

41. Since 2016 I had a disciplinary for leaving a door open but there was no further action taken and I can't remember specifics. I have not been involved in anybody else's disciplinaries or grievances.

Staffing Levels

42. I didn't work wings so cannot really comment on the impact of staff shortages on detainees on the wing.

43. In my opinion however staff shortages were detrimental to staff safety. For example, having only 2 staff on a wing is one to 50 ratio, so if something kicked off there would not even be enough people to do a control and restraint as that requires a minimum of 3 people. You knew that if you pressed a red button the staff would be there for you, but they can only get there as quickly as they can so in my view safety was inevitably compromised. I don't think that at the time it did have a particular effect on morale. The staff were all long serving staff members and they all knew each other. They were like one big family but over time, long serving people have left and the morale is nowhere near the same as it was.

44. In my opinion the staffing levels of the Healthcare team was poor. I cannot comment upon staff morale aside from the frustration that we experienced caused by difficulties in getting hold of them, but I believe that it had an impact on staff safety to some degree. First response requires 2 members of the healthcare team to respond, and therefore if that person was doing admissions with us, they would have to leave us to respond and that would leave detainees in the reception area perhaps for hours causing frustration and disruption. We would have to try and alleviate that and there is only so long that you can tell someone to please wait before they get too frustrated.

45. I thought that the staffing levels of the activities team at the time were good.

Tinsley House Staff

46. In my opinion Tinsley House and Brook House staff all received the same training. I don't think that Tinsley House staff were given any extra training. We all went on the same training course and we all had to shadow both centres and know what it was like to work at both centres. They can do the job as well as we can if not better. In my opinion the Tinsley House staff have the time to learn their jobs really well. They have a wider breadth of knowledge and get different clientele. In that respect they are probably better trained than Brook

House staff. I don't feel that working at Brook House would have come as a shock to them as there was always cross deployment. I know they didn't like coming to work at Brook House, but when they did come up there were never any issues highlighted as far as I am aware.

Treatment of Detained Persons

Immigration Rule 35 Process

47. At the time I was not involved in the Rule 35 process. I therefore cannot comment on the process, but I think it could be lengthy depending on demand.

Use of Force

48. I was involved in a use of force incident against D2159 on 5 April 2017. The use of force report is at **CJS005529** and my statement appears at pages 22 to 23.

49. Upon review of my statement, I note that D2159 was initially non-compliant.

50. At the time of the incident, D2159 failed to follow any instructions that we gave to him, he went rigid and he would not walk with us.

51. It was deemed necessary to use force at the time in order to move the detainee for his own safety. In my opinion, it was low level use of force; my statement details the C&R/MMPR techniques used.

52. Aside from this incident, I have only used force on a handful of occasions although I can't remember the specifics. I didn't deal with any severe use of force incidents.

53. We considered lessons learned within refresher training but I believe that that was after the relevant period. Following a Use of Force incident, you had to complete use of force paperwork and include an incident report. Everybody involved completed an incident report. I would give the completed paperwork

~~to my manager for comment and they would also send it to senior management~~ and then the Home Office. There would also be a debrief following a use of force Incident which would include consideration of lessons learned.

54. I did not have any concerns about any incidents that I was involved in or any incidents that I was not involved in.

55. I think control and restraint is effective as a mechanism to control detainee behaviour. I can't think of an alternative. De-escalation techniques were used throughout control and restraint to try and reduce the level of resistance from detainees to gain compliance so that you could reduce your level of control and restraint. As detainee behaviour reduces you would then reduce your hold. If they build back up you build back up. Use of force is governed by detainee behaviour. Before you use force on someone you try talking to them. If I saw something building, I would try to take the detainee somewhere quiet where it was just them and me although in sight of another staff member. I often find that if you remove the detainee from a scenario that can be helpful. The first step is communication, to find out what is causing the problem and establish whether it can be resolved. We were expected to use interpersonal skills and to try to be empathetic to resolve the problem if possible. The people I worked with had a lot of experience and taught me how to reduce my risk as much as possible. However, de-escalation is not always successful but use of force is last resort.

Detained Person's Welfare

56. I completed mental health awareness and safeguarding training, but I can't remember when. During the relevant period I believe that I had completed safeguarding training but not mental health awareness. Safeguarding is a department, but everyone undergoes safeguarding training. It covers diversity, inclusion, equality, ACDT, self-harm, vulnerability, adults at risk (a lot of things in one). You watch a video re self-harm and schizophrenic delusions and what you can do. It covers spotting different kinds of mental health issues but in my

view is very limited. That said as I did a criminology and psychology degree my perception of the quality of the training is coloured by that. I think mental health training would have benefited us during the relevant period. It gives you a better understanding of the breadth of mental health issues that you might encounter.

57. Healthcare primarily dealt with mental health issues and assessment, but we had to be able to identify potential issues in order to make the referral. However, healthcare would then take the lead on management and care of the affected detainee.

58. If an individual self-harmed or we felt that there was a risk of self-harm an ACDT would be opened, an Incident report written, and healthcare attended ASAP. The process was the same in either case although if the detainee hadn't self- harmed there would be no Incident Report. The severity of issue determined what happened next. If less severe it would be treated on site. Detainees were seen by healthcare and then constantly monitored. I believe the process to be effective.

Individuals as time served foreign national offenders (TSFNO)

59. I dealt with the TSFNOs when they entered Brook House as I worked on reception. The same process was followed for TSFNOs and non TSFNOs. We sometimes had difficulties with information as not all came with their prison file, and therefore we did not have all information on movement orders (a document created for the movement of an individual coming into or leaving the IRC), which made it difficult to risk assess. In addition, sometimes movement orders had so much information on them that information would be missed. For example, we had one person who came in 4 times – on one occasion he had committed a sexual offence whilst in prison but the next time he came in that information was missing. I knew that that information was missing but he had also had so many incidents within the IRC estate that the information transferred was all about IRCs and not his prison record. I wouldn't say it caused delays but missing information would make it more difficult to risk assess the detainee for

example in this instance for room sharing, and a detainee would have to be accommodated by themselves until the relevant information was available.

60. I didn't treat TSFNOs any differently from non TSFNOs. If anything, the TSFNOs required less attention because they were more aware of the situation they were in and for them it was a better environment. A non TSFNO was not used to the environment. A person who has come from a prison background is quicker to book in. Someone who is not used to that environment might need more explanation or have more questions. If you have never been in a prison environment or a detention centre it is daunting. You have to take time to make sure that they understand where they are what is happening and what to expect.

61. I didn't work wings so can't really comment upon whether the co-location of TSFNOs with other detained persons caused difficulties in managing the welfare and/or behaviour of individuals.

Abuse of Individuals Detained at Brook House

62. Whilst working at Brook House I did not have any specific concerns about the abuse (verbal or physical) or detained persons either individually or collectively by staff. Neither did I have concerns about the abuse of detained persons by other detained persons either individually or collectively. There were fights between detainees, but I know that through word of mouth not through actually seeing it.

Impact of delays on detainees

1. It was a difficult time within healthcare during the relevant time and it felt like we were fighting a constant battle due to their not seeing admissions within two-hour time frames and all going on lunch at the same time, although I cannot remember any specific dates or times when this happened.

2. As well as providing care, healthcare's role was to check the stats of a detainee for example, their general weight, height, blood pressure. They also get information regarding allergies, religion, medication and health issues; generally, things that you would need to know about an individual to properly care for them.

3. I should clarify that if a detainee needed urgent help or care it would always be given to them. The delays that I referred to did not relate to urgent healthcare needs. I would try to be understanding of the demands placed on the healthcare team, for example, if a detainee had self-harmed on a wing and healthcare had attended to them, I would not call healthcare to request that they deal with someone who was uninjured in reception.

Complaints

4. There were complaint forms in every area, in multiple languages, which detainees would fill out, and there was a box to put them in. If anyone had asked me for help, I would give it but I have never been asked.

5. I was not involved in any investigation either conducted by G4S or the Professional Standards Unit in relation to a complaint made against me or another member of staff.

6. I don't feel I can comment upon how this process could be improved as I have not been involved in it.

7. I believe that the process for individuals who wished to make complaints about any other matters including healthcare would be the same.

The Panorama Programme

8. I remember working with Callum Tully when I was working in visits as an ACO and I knew of him.

9. I do not appear in the programme.

10. I believe that the Panorama programme had a detrimental effect upon morale. The content of the programme was shocking and staff feared that they were all tarnished by the same brush. Everyone was shocked and though the vast majority of staff had done nothing wrong, we felt that we had because we were associated with the events depicted in the programme. Before the programme I was proud to work where I worked but when it came out, if someone asked you where you worked you were suddenly reluctant to say.

11. In addition, I know that on occasion on arrival some detainees came in and would ask if this was where they videoed panorama. I was quite honest and said yes but tried to reassure them that things had changed and try to reassure them. I wasn't working on the wings however so can't really assess the impact on morale on the wings.

12. I haven't dealt with age disputes so cannot comment on this safe to say that a detainee's date of birth was included in the movement order and if a detainee claimed to be under-age the matter would be escalated to a manager.

13. I'm sure there were changes made after Panorama, but I can't recall them.

Specific Individuals

14. I worked with most of the individuals listed at question 63 of the rule 9 letter from the Inquiry aside from Steve Webb, Kalvin Sanders, and Charlie Frances. I don't know who Shayne Munroe is and can't recall Nurse Jo Buss. I had no concerns about any of them and did not witness any bad behaviours or hear any derogatory remarks. If I had heard any derogatory remarks I would have talked to the person in question and if getting nowhere I would have raised it to a manager or rung the whistleblowing line. If I had witnessed physical abuse, I would have reported it immediately.

Suggestions for Improvements

15. I can't think of improvements that could be made to improve individual health, safety and welfare.

Any other concerns

16. There are no other matters relating to the culture at G4S at Brook House or the treatment of detained persons that might be relevant to the Inquiry.

17. I am not aware of any specific individuals who might be knowledgeable about the matters mentioned in my statement and neither am I aware of any further matters that are relevant to the Inquiry's work.

Statement of Truth	
I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth. I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.	
Name	Megan Cunningham
Signature	**Signature**
Date	10.02.2022