

BROOK HOUSE INQUIRY

First Witness Statement of Conway Edwards

I, Conway Edwards [DPA] providing this witness statement in my personal capacity, will say as follows:

Introduction

1. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 18 February 2022.
2. The below statement is accurate and true to the best of my knowledge and memory of the period 1 April 2017 – 31 August 2017 (the "Relevant Period"). Since receiving the Rule 9 questions, I have had access to, and the opportunity to review, documentation that relates to the Relevant Period to assist me in providing detail. The documents I have been asked to consider are referenced within this statement.

Professional Background

3. I worked for two previous companies before commencing employment with G4S. The first of which was Argos. I initially joined Argos as a Christmas temporary staff member in one of their high-street stores. I was subsequently offered a permanent employment contract following the Christmas period, which I accepted. My role involved working in all areas of the shop. Including operating the collection point, the tills, and working in the stock room. I was promoted to a Stockroom Team Leader after a number of years in this role.
4. Following Argos, I started working for Blackjack Experimental Agency. I initially joined Blackjack in a marketing role, working on new product launches around the UK.

However, shortly after joining, I was transferred to Gatwick Airport to work in their Information Point. This involved interacting with thousands of passengers in various stages of travel and circumstances at the Airport. After a year in this role, I was promoted to Team Leader. Within this role, I was responsible for managing up to 25 staff on a daily basis. Other duties involved overseeing various areas at Gatwick Airport and ensuring that high standards of customer care were provided at all times. I made sure that staff were approachable and friendly whilst providing passengers with correct information throughout the entire Airport.

5. I started working for G4S on 28 February 2011. Upon joining the Company, I completed a six weeks induction and training course followed by a couple of weeks shadowing more experienced staff members in their day to day duties.
6. Following the completion of my shadowing period, I was formally allocated to work in the Removal from Association and Temporary Confinement and Patrol Line/Department ("RFA/TC") based in Brook House. The RFA/TC is now referred to as the Eden Wing. At this point, I was also given access to the staff keys for the centre.
7. I stayed in this role in the RFA/TC for two years. I predominately worked on the RFA/TC throughout this period, however, at times I was required to work on other wings or assigned as a patrolling officer.
8. In 2012, I recall that I was voted as 'Employee of The Month' and 'Officer of The Year'. Due to the passage of time, I am unable to remember the exact reasons as to why I was awarded these titles. However, I do believe that it was somewhat related to being a reliable member of staff and also my involvement in an incident in 2012, where my quick response saved a detained person's life.
9. In February 2013, I successfully applied for the role of Diversity and Race Relations Manager.
10. My role as Diversity and Race Relations Manager evolved over time. For example, I was required to take on additional responsibilities in the Safer Community department when the Safer Community Manager at Brook House retired and was not replaced.

11. Historically, there were two Safer Community Managers working in conjunction with each other for Tinsley House and Brook House. One manager was based at each centre. There has only ever been one Diversity and Race Relations Manager across Tinsley House and Brook House, which was my role at the time. The three of us worked in collaboration to provide services across both sites. At this time, we were all also being managed by the same line manager. I am unable to remember exactly who was acting as our line manager during the Relevant Period as it changed a number of times, but it may have been Michelle Brown who was the Head of Safeguarding.
12. As such, when the Brook House Safer Community Manager retired, I was asked to take on more responsibility under the Safer Community remit. As part of this additional work, I was required to undertake checks on the Assessment, Care in Detention and Teamwork ("ACDT") documentation, work surrounding the use of the Safer Community Hotline and Log Checks, amongst other things.
13. Serco took over the Home Office contract for Gatwick IRC in May 2020 and I was subsequently TUPED over to Serco.
14. Sometime between May 2020 and July 2020, Serco issued an update to staff which showed that my position, Diversity and Race Relations Manager, was to become a Detainee Custody Officer's ("DCO") role. The same happened with the Safer Community Manager's role. On 28 September 2020 the name of my existing role was changed to DCO under Serco. At that same time in September 2020, I moved into my current role of Detention Operations Manager ("DOM") based at Tinsley House.

Professional Qualifications

15. In terms of professional qualifications, I have completed a BA (Honours) Degree in Graphic Design.
16. I have also completed the following training courses throughout my working life:
 - Institution of Occupational Safety and Health, Managing Safety Training Course;

- Bronze Commander Course
- Safeguarding Adults V5
- Preventing Bullying Behaviour
- Child Protection
- Children's Rights
- Level 3 Award in Education and Training; and
- First Aid at Work Training Course.

My Training

17. I have reviewed document VER000224, which is a transcript of my interview for the Verita investigation.
18. With reference to my training received for my role as Diversity and Race Relations Manager (as discussed at page 3 of the transcript), I can confirm that I did not feel as if this training sufficiently prepared me for this role.
19. I believe that this is mainly because the person who had been working as the Diversity and Race Relations Manager prior to me had left some months before I was given the position and as such, there was no formal handover or clear processes in place.
20. The shadowing and assistance that I received from Sarah Edwards went a long way in giving me an idea of the role, such as what is required; reports, types of meetings I needed to attend, investigations and various other things. However, I do not believe that this was sufficient training. A lot of aspects of the role were not covered.
21. It would have been beneficial if I was allowed to have visited other G4S centres and was able to speak with staff in similar roles prior to commencing work as a Diversity and Race Relations Manager.
22. Prior to starting this role, I did think that I was going to receive a recognised qualification to assist me with carrying out my duties. There were also a number of training courses that I had requested to be booked onto to prepare me for this role, but

my requests were refused because of funding. I therefore had to write and submit a number of Business Cases that provided justification for undertaking the courses that I had identified and explained why they would be beneficial. These business cases were discussed with my Line Manager at the time, Michelle Brown, and during my Employee Development Review ("EDR").

23. After a while working as Diversity and Race Relations Manager, it became clear that I was not going to be granted access to my requested courses through G4S.
24. As such, when I saw an incentive scheme was offering a number of courses, including an Equality and Diversity NCFE Level 2 Course and a Team Leader Course, I signed myself up to complete both courses. I recall that this scheme was run by West Sussex Council. I do believe that these courses assisted me in my role as Diversity and Race Relations Manager.
25. I remember that I was always keen to continue my training and had identified a number of courses being run by CMI and other suppliers. Some of the courses I wanted to complete were a natural progression from the previous Level 2 course and I wanted to complete Equality and Diversity NCFE Level 3 and Equality and Diversity NCFE Level 5, for example. I therefore continued to submit requests for access to courses or funding from G4S so I could book my own training, but this was not granted. I recall that the courses I was looking at cost in the region of £700-1,500
26. As highlighted on page 3 of document VER000224, I did receive training on how to deliver 'Acting Inclusively' training to other staff members and Level 2 Equality and Diversity training. However, I was led to believe that I was elected to receive this training following a Business Case that I had put forward. Although when I arrived at the training, I quickly realised that the purpose of the training was to train me on how to deliver a training course on the same topics to staff members back at G4S. I understood that this was a course that G4S was planning on rolling out to all staff in a custodial setting.
27. Despite the fact that this training was not specifically requested by myself, I do feel as if the training was beneficial to me in carrying out my role of Diversity and Race

Relations Manager. Particularly as an element of my role consisted of training staff on equality and diversity matters.

28. Further training was also provided to me on Adult Safeguarding in July 2018. However, I do believe that it would have been beneficial to have had this training in advance of starting in my role or at least within the first 6 months of being Diversity and Race Relations Manager.

Staff

29. The inquiry has asked me to list all staff members whom I have had concerns about in terms of their attitude and set out any actions taken in response. Due to the passage of time, I do not remember the exact details or every case that I dealt with. Without sight of the formal records in respect of each staff member, I am unable to comment upon what specifically took place.

30. I do have a vague recollection of certain cases, and I have listed the details of these below to the best of my ability. I will take each one of these in turn:

- Duncan Watts - I overheard him swearing at officers during a roll count at lock up. Duncan was a DCM at the time. I do not remember what action I took in response but as a result he had to apologise to all the staff.
- Sam Gurney – there were a number of complaints submitted about Sam's attitude. Once again I am unable to recall what action I took in response to the complaints.
- Rachel Allison – I recall that Rachel was dismissed for making inappropriate comments about another staff member. I cannot recall my exact involvement in this decision to dismiss Rachel, nor what the comments related to.
- I recall that I had prior discussions with Ryan Harkness regarding his tone and how staff may perceive him. I cannot remember what prompted this conversation or if any further action was taken.

31. I also remember having concerns about the attitude of Darren Tompsett, and two further staff members called Tom and Rebecca, the surnames of whom I cannot remember as they were dismissed from the Company.
32. With reference to my comments on page 22 of document VER000224, I do not recall having any concerns that members of staff would come and see me with their concerns or issues rather than going to their designated Line Manager.
33. Unfortunately, due to the way the shift patterns fell and working arrangements, it was not always possible to have staff members working on the same day as their Line Manager. It was luck of the draw as to whether you were or not.
34. Personally, I think that staff members spoke with Managers who they either trusted or who had a good reputation throughout the workforce. This is only natural, and I imagine is the same at every workplace. Another factor may be that some Managers were more approachable to some staff than others.
35. The Inquiry has asked me to explain any actions I took in response to DCO Tulley raising a concern about ACDT documents being submitted late. Any issue raised regarding ACDT documentation would have been addressed in a number of ways depending on the complaint or concern raised. Any action taken would have been led by the Safer Community Team. I was involved with speaking to Unit Managers and Officers on the wings. I would also compile a report to send to my Line Manager, Michelle Brown, which highlighted any concerns. Depending on the report, Michelle may issue notices to staff for non-compliance with ACDT policies and procedures.
36. As mentioned above, there are different steps that may need to be taken depending on the issue or concern raised. For example, there are different requirements for issues such as a missed observation, late observation, poor observation, or relating to the timing of checks. Action taken in response includes amongst other steps, talking to the staff member(s) concerned, issuing a formal letter, re-training, or opening a formal investigation if warranted.

37. I have been asked to consider the comments made by the Independent Monitoring Board ("IMB") in documents IMB000093 and VER000229 and expand upon my involvement with staff relations. I can confirm that my involvement included talking to staff, delivering training and completing investigations. These were either issues between staff members or between detainees and staff. I believe that through my involvement in these matters, staff members were more inclined to come to see me more and more regarding a range of issues.
38. To ensure that I was kept aware of how staff were feeling, I would talk to staff on a daily basis when I was on shift and also interact with them during training sessions that I was delivering. I delivered training to both new and existing staff members.
39. I believe that I built a good rapport with new staff completing their initial training course ("ITC"). This was because I would deliver a full days' worth of training on Acting Inclusively during the ITC and it was a great opportunity for me to make a good impression and introduce myself.
40. I do not believe that low staffing levels were the only cause of low staff morale at Brook House during the Relevant Period. When I started at Brook House, staffing was exceptionally low. As such, there were days when I had to unlock a Wing by myself, which at the time was normal to some extent. I now spend limited time at Brook House in my current role, but from what I see, I do think that the staff morale has considerably improved in Brook House compared to how it was during the Relevant Period. This could be linked to the fact that there is more staff working at the centre, but I do not think this is the only reason.
41. Staff morale has also increased at Tinsley House. Although, I do think that morale can still be low on occasions for a variety of reasons. For example, at present in Tinsley House, staff morale can be affected by shift patterns, whether staff feel valued and supported by their Line Managers, or if there is insufficient engagement from the senior management team ("SMT"). External pressures from Agencies such as the Home Office or the IMB may also reduce morale. At Tinsley, for example, the Home Office sometimes schedules departures and DEPMU send us new arrivals to take place around the same time, which causes pressure on staff members. That is why I say that I do not

think low staff morale is not exclusively linked to staffing levels, there are other factors too.

42. I have previously had conversations with the Director, Ben Saunders, regarding staffing and engagement from the SMT. I cannot recall when these discussions took place. I do recall speaking with Ben on one occasion after I had returned from assisting at Oakhill with training due to them being short staff and having to run three ITCs at once, in an effort to refill their staff numbers. Upon my return to Brook House, I voiced my concern that if something was not done to try and retain staff, then we will soon be left with no other option but to run back-to-back ITCs like Oakhill. I remember that action was taken to look into staff retention shortly after this.

43. I have been asked to comment on the statements concerning the SMT made within the Dominic Aitken interviews of DCO Edmund Fiddy and DCO Luke Instone-Brewer (documents INQ000088_2 and IN0000087_3). I cannot confirm the accuracy of someone else's opinion. However, from speaking to staff on a day to day basis and whilst delivering training, I formed the opinion that the SMT were not making themselves accessible enough. I recall that I did speak to Ben Saunders and Michelle Brown about my concerns.

44. I did believe that it was my responsibility to undertake welfare checks on the staff I managed. As stated above, staff used to come and speak to me about any concerns or issues. I believe this was because staff felt as if I was someone who they could talk to and I would understand. Staff members spoke to me about a wide range of issues, whether this was in relation to work or problems outside of work.

45. I have reviewed document VER000262_17 and can confirm that I have never delivered Mental Health Training to staff. I myself have only ever delivered Acting Inclusively Training. James Begg at the time would have delivered the Safer Community training section to the ITC, which would have included an introduction to mental health.

Brook House Culture

46. The Inquiry has directed me towards page 20 of document VER000224 where I provide my opinion that, in the past, there has definitely been a culture of inappropriate 'pally-ness' between DCMs and DCOs at Brook House. Such that DCMs would laugh and joke with DCOs rather than challenging any inappropriate behaviour.
47. I cannot remember a specific time period when I thought this was the case, however, I believe that it may have been from 2015 to 2017.
48. I do feel as if this culture could have potentially had a negative impact on the care provided and wellbeing of detainees at Brook House. However, I am unable to say this with certainty.
49. It is difficult for me to comment on the culture at Brook House at present as I am now based at Tinsley House. At times I am cross deployed to Brook House, but I am aware that there has been a big intake of new staff recently so the culture may have changed.

2016 IMB Annual Report

50. The Inquiry has directed me to a record of an IMB meeting that took place in May 2017 (document IMB000030_5). The record states that a copy of the IMB Annual Report for 2016 (CJS000770) was sent to me.
51. I cannot recall if the report was sent to me directly, however, I would have seen the report at some point after it was shared.
52. Similar to the above, I am unable to remember the exact steps that I took upon reviewing this report for the first time. Nevertheless, it was likely to involve reviewing policies, procedures, training, and creating and or updating Continuous Improvement Action Plans amongst other points.

Document VER000232

53. I have considered the interview transcript of Mr Williams in document VER000232. At page 6, Mr Williams explains that I produced "a monthly stat along with James of

violence within the centre, assaults on staff, detainee-on-detainee". I can confirm that I obtained the stats and figures produced in these reports from a Security Information Log that was circulated by the Security Team on a monthly basis. This log recorded all Incident Reports, Rule 40s, Use of Force incidents and Security Information Reports ("SIR") for that month. I then extracted this information to build my reports and identify where we were experiencing issues and highlight any trends or hotspots. The report was also a requirement under schedules D & G of the Gatwick contract. The Safer Community Team would use the information contained in the report to address any issues raised and improve processes where required.

54. The reports produced were also sent to the SMT, Home Office, IMB, Healthcare, Forward Trust, Samaritans and all DCMs. The reports were then reviewed at the Monthly Safer Community and Diversity Meeting, which originally started off as being done every fourth Tuesday at Tinsley House and Wednesday at Brook House. However, the group eventually decided to combine both meetings into one.
55. Following each meeting, actions would be issued to certain individuals or teams. For example, if it was identified that there was a lack of activity at a specific time and this was causing altercations, then an action would be issued to a person/department who would then be responsible for rectifying the issue.
56. At page 21, Mr Williams stated that he believed staff to be quite astute as to safeguarding issues and would report any issues to me and/or Mr Begg. I am of the opinion that Mr Williams made his statement based on how he was feeling at the time. However, through the ITC, staff were made aware that there was a Safer Community Team and as such they should seek to report any concerns they have regarding detainees to this team.
57. In my opinion, I think that the Safer Community Team should have consisted of four DCMs and two dedicated officers due to the amount of work that was required. This would have also lessened the impact caused by shift patterns, holidays, sickness and either delivering or attending training sessions.

58. I remember having a discussion with Ben Saunders regarding having two DCOs allocated to us and his response was along the lines of "that is why I pay you guys". I also raised this issue to Michelle Brown after we were visited by a DCM from HMP Parc who told me that they had a team of four DCMs looking after diversity alone and also had officers to assist.
59. I cannot recall ever hearing a circumstance where staff members had safeguarding concerns about a detainee and yet there was not a report.
60. With regards to whether staff would have benefitted from formal training on safeguarding, I think that training is always beneficial, providing it is the right course and fits the requirement of what is required by the staff to fulfil their role.
61. The main issue with training is that G4S in my opinion focused on providing in-house training which may have not been sufficient or what was required. Whereas, I personally wanted to do recognised courses but my requests to do external courses were turned down.

The Independent Monitoring Board

62. I can see from document IMB000066_3 that there was a suggestion that orderlies should be used to spread the word of the role of the IMB to detained persons.
63. In my opinion, detained persons were aware of and able to access the IMB. From having seen IMB on Wings, attending forums, and in a range of other scenarios, such as attending planned or spontaneous use of force interventions. Although I am aware that the IMB were not in the centre 24/7. To combat this issue, the residents were provided with IMB boxes that they can use to make contact with the IMB. Only the IMB has access to the contents of these boxes. Residents are informed of the purpose and locations of the IMB boxes during their induction process and compact they signed within their first few days into the centre.
64. The IMB boxes are also located next to the Home Office Complaint boxes. The main difference between the different complaints processes is that the Home Office has more

of a formal procedure in place for responding to complaints submitted. For example, unlike the IMB, the Home Office has set time frames within which they must investigate and respond to a complaint and the complaint boxes are checked every day by a member of the onsite Home Office Team.

65. There are no set rules or policy that stipulate that a certain type of complaint must be submitted to either the IMB or Home Office. I normally advise residents to use the Home Office complaints box purely because this is a more formal process and the fact that the complaint boxes were checked daily.
66. There were also dedicated IMB information boards around the Centre and on each wings, which included specific IMB information. The IMB meetings were also attended by detainees. I cannot specifically recall the exact details of any further steps that were taken to ensure detained persons were aware of and able to access the IMB during the Relevant Period.

Incidents involving racism and racial abuse towards staff

67. I have considered document IN0000087_2, at which DCO Luke Instone-Brewer shares his opinion that in July 2017 staff had insufficient deterrents to challenge the abusive behaviour of detainees, and may out of frustration use bad language back, and are then suspended. At page 3 he explains that he "thinks it's harder if you're black in this place. My friend Babs gets a lot of grief from the [detainees]. They call him things like coconut, a traitor and stuff like that".
68. Personally, I do not think that there was a lot of support available for staff receiving racial abuse from detained persons. However, I do appreciate that the adequacy of support provided depends on what staff would have liked to have seen in place in such circumstances.
69. There was a Care Team in place who were available to support members of staff involved in these incidents. Although I am aware that staff members felt as if this system alone was not enough of a support mechanism.

70. I am also aware that there was a perception from staff members that not enough was being done to resolve these issues or sanction detained persons. For example, certain staff members called for detainees to be removed from association following incidents involving racial abuse towards staff.
71. At some point, the Home Office removed the Incentive and Earned Privileges ("IEP") scheme as it was felt that it was not suited to an IRC environment but rather should only be applied in prisons. I believe that this action followed a recommendation made within Stephen Shaw's review into Detention Centres and other places of custody.
72. Following an incident of racial abuse towards staff members, staff were able to complete SIRs, Incident Reports and/or issue detainees with a formal warning should they feel it warranted such action.
73. In my own experience, when a detainee called me a coconut amongst other discriminating words, I have spoken to the detainee, submitted a SIR, and issued the detainee with a formal warning where required. The SIRs submitted are recorded on file and help build a picture of the detainee in question.
74. I have reviewed document IN0000090_6-7, within which Michelle Brown remarks that I was the first black manager appointed at Brook House. I can confirm that I have faced difficulties in the past because of this. As previously mentioned, I have been racially abused by detainees during my time at Brook House.
75. I have also experienced discrimination because of my race from staff members. For example, during my first six months of working on the RFA/TC, DCO Paul Cowhig and DCM Ian McDonald, participated in creating a picture of the RFA/TC Team which showed all other staff members in blue and me in black.
76. I also remember that in the first two months of acting as Diversity Manager, I was moved from the Office that was used by the previous Manager and placed in another with the residential DCMs. I was given a desk and the choice of space in this office. However, after a few days, I started having a number of issues happening with things

going missing to coming into the office in the morning and there being rubbish all over my desk. It was apparent that someone had emptied a bin onto my desk.

77. I can also recall a time when I questioned how a random staff search that had been carried out because two BAME staff members had informed me that the Security Manager Caz Daz-Jones who was responsible for conducting the search had only waved white officers through without searching them. All I said was that some staff had felt picked on because only BAME staff had been searched and it would be beneficial for future searches to have a system of it being random in everyone's eyes and/or you search everyone on the day.

78. I do feel as if I was partially supported through some of these previous incidents I have mentioned. For example, I especially recall that I reported the issue with the rubbish being emptied onto my desk to Michelle Brown who was at Tinsley House at the time. In response, Michelle asked me to come to Tinsley before the end of my shift that day. I recall that I had a meeting with Michelle and Nathan Ward to explain what was going on. The next morning when I came into my office, the other desks had been removed from the room leaving just my desk on its own. I am not aware of what was said to the other Managers who were moved.

79. However, with regards to the searching incident, I was made to look like a trouble maker. I was subsequently told by my Line Manager to "stick to Diversity". I recall that I was surprised and shocked by this response.

80. Another issue I have faced is where I was told to issue a staff member with a written warning by the then HR Manager, Shaun Collins, prior to holding a sickness meeting with the staff member in question. I knew that this was wrong and against policy. So, instead, during the meeting with the staff member, I listened to them during the meeting and considered the evidence available. Following this meeting, I actually made a decision not to issue a warning based on the evidence. As a result of my decision, I felt that Shaun tried to bully me by sending a number of emails to me regarding my decision taken with almost all of the SMT group in copy. I do not know whether this was because I was black, but I do not feel as if he treated other managers in the same way. Ultimately, as Shaun had instructed me to issue a warning in contradiction to the policy that was in

place at that time, I was able to quote the policy in a response email and he backed down.

81. I also recall one time when there was a position opened up for secondment into the Safeguarding role. I submitted my interest, as it was required. The interviews were to be held by HR Manager Shaun Collins and Deputy Director Sarah Newland. I knew that I was going away on holiday and would not be in the country so I told them that I would be happy to have the interview before 10 August 2019 or after 24 August 2019. On my return home following holiday, I found that I have received a letter dated 16 August 2019 in the post inviting me to an interview on the 21 August 2019. The moment I saw the date, I strongly believed that this was a deliberate attempt to give the position to one of their favourite staff members. Upon my return to work following my holiday, I recall that I also overheard the Detail Manager asking if he should move the successful candidate's shift pattern line over to suit the new role. This was weeks before the outcome of the interviews was announced to everyone who applied. I do believe that this however was more about favouritism rather than racism.

Equality and Diversity

82. I have reviewed the Equality Policy at document CJS000705. I believe this Policy was in place until Serco took over the running of the Gatwick contract in May 2020. I cannot recall the last date the Policy was updated prior to this.
83. All staff members would have been made aware of the Single Equality Policy and the accompanying Single Equality Policy Statement during the ITC.
84. The Acting Inclusively training is provided as part of the ITC and covers the G4S Equality policy, this was usually set within the first week. Although the training package was set by the Central Training Department and was not updated for a number of years, I was allowed to include policies and procedures we had at a local level.
85. Refresher training did not touch upon Diversity and Equality. The Single Equality Policy did therefore not form part of annual refresher training delivered to staff, as far as I can recall.

86. The Inquiry has referred me to my Verita interview at document VER000224_5, within which I explained that the Policy dictated that staff should have race relations and diversity training as part of ITC and annual refresher, yet it was taken off the refresher course with the intent of full-day 'acting inclusively' training and would later be reintroduced to refreshers.
87. I recall that it was decided that the Acting Inclusively training needed to be provided because it was more comprehensive and all staff were required to complete it. Once all staff had completed the training, it was then to be included in refresher training.
88. I cannot remember at which meeting it was decided and/or upon whose instruction it was that the 'Acting Inclusively' training should replace the Diversity training that was delivered in the Refresher. Whoever was the Training Manager at that time would be better placed to answer this question.
89. Initially I would say that the full-day of 'Acting Inclusively' training was very successful. In that, there was a noticeable reduction in bullying, and staff started to challenge and report inappropriate behaviour.
90. I have been provided with document VER000224_6-7 which describes monthly Equality and Diversity Inclusion Action Team meetings. The purpose of these meetings was to review the reports that highlighted any issues, emerging trends and hotspots.
91. I am recorded in document VER000224_6-7 as saying that if I was in the room, people would take it seriously. However, I can confirm that this comment was not in relation to these meetings. Instead, this comment was made in relation to being in the break room.
92. I cannot recall how often I was unavailable to attend these meetings. This would have depended on my allocated shifts. Initially, I tried to swap my days off and/or come in if the meetings were scheduled on my days off so I could attend every meeting. However, after a while, I had other responsibilities to consider which meant I was restricted in my ability to swap days.

93. Having sat in a range of meetings, I have zero doubt that the staff attending, planning, and/or chairing these meetings would have still taken them seriously in my absence.
94. I note that document VER000237_7 records Mr Jones' comment that in the diversity meeting, "you get massive amounts of information but I'm not sure how helpful that information is necessarily [...] you need bullet point action plans and who is going to do what by when". Ms Lampard added that "I didn't feel that the meetings themselves were focused, as you rightly said, on the future on planning. It was just a recitation of what the status of individuals is".
95. This is talking about two completely different meetings, the comment regarding the recitation of individuals' statuses is in relation to the Adults at Risk meeting. This was a new meeting that was arranged in response to DSO 08/2016. I believe that this meeting became more focused over time.
96. I believe that there is also a lack of understanding regarding who has the power to decide upon and implement changes. These are multi-agency meetings and as such, everything must be agreed to by all parties and properly planned out. I.e., who is responsible for what actions.
97. The first months of these meetings involved talking about all Adults at Risk. However, the scope of these meetings were eventually narrowed down to only focus upon individuals at Level 2 and Level 3. This was because of the high volume of individuals at Level 1, there were simply too many to discuss in one meeting.
98. I do not agree with the criticism that the meetings were insufficiently focused on future planning for the detained persons. The individuals dictated what planning could have been done, in that, we did not know what would be the outcome of their case and as such, it would not be beneficial to have a single plan because it may be that the individual is released rather than go on a flight and or flight.

99. More specific forward plans could and have been drawn up for detainees who were identified at Level 3, because the majority of the time we would be given more information regarding the next step.

100. I have been directed to consider document VER000224_9, within which I comment that there is a low proportion of staff that are BAME at Brook House. I recall that there used to be a lot of complaints from staff regarding bullying, harassment, victimisation, and there needs to be a constant cycle of reinforcing messages about not bullying or being racially abusive to staff. I cannot recall the extent of which these complaints were related to racism among staff members.

101. I can confirm that there was a change in the proportion of BAME staff employed at Brook House in the wake of Panorama, but I could not say what the percentage is now. There was an intensive recruitment drive by Serco.

102. The Inquiry has asked me to confirm what I meant by needing a "constant cycle" of reinforcing those messages. What I mean by this is that it is important to ensure that staff are continuously made aware that: (i) we do not tolerate such behaviour; and (ii) there are formal processes in place that can be used to report any behaviour they believe to be inappropriate.

103. At present, reinforcing messages about not bullying or being racially abusive are given to staff through training and poor behaviour is also challenged via utilising the disciplinary policy to demonstrate that any such behaviour will not be tolerated or accepted.

104. I have reviewed document IN0000076_2, within which Sarah Walpole describes hearing through detained persons that officers might call them "paid" or be derogatory to colour, and that staff "should be screened for any sign of that because you shouldn't be here". I myself cannot recall ever hearing anything similar from detainees or anything of this nature being reported. I was aware, however, that detainees said on many occasions that they wanted to see more managers that represent the BAME community.

105. Since the Relevant Period, the recruitment process has been updated with additional steps that are designed to check the attitude of staff before they are employed. The new process involves including existing DCMs within interviews and also introduces a new section on Equality and Diversity, which candidates are scored against.
106. I have considered document VER000224 _13-14 which records my recommendation that changes be made to the disabled bathrooms in terms of the positioning of call bells and their accessibility. I cannot remember when I first raised these concerns, however, I am aware that my thoughts on this were included in my annual reports over the years and were also be raised at the monthly Equality, Diversity and Inclusion Meetings.
107. I also raised these concerns and associated recommendations to the SMT. Following this, the Facilities and Residential Managers were instructed to obtain a quote to complete the required work. I believe that the quotes subsequently received were within the region of £9,000 per bathroom, which I believe was the sticking point.
108. I am pleased to report that my recommendation was implemented in all of the disabled bathrooms. However, I cannot recall the exact date(s) when this work was undertaken.
109. I explain in document VER000224_10 that I try to monitor the proportions of nationalities on each wing to ensure that there is an equal mix of nationalities so as to reduce the chances of large fights or groups forming.
110. This process of monitoring is undertaken by talking to staff members across all wings, visiting the units and monitoring any complaints received. I am aware that all DCMs are also required to report nationality statistics to the Residential Manager. This is another way in which nationality figures on each wing are monitored.
111. The inquiry has referred me to documents VER000224_19 and DL0000142_28-30 which comment upon whether staff recognise their responsibility for equality, diversity and inclusion. I believe the reason why a handful of staff members listed me

as having responsibility was because staff answered the question with who they believe to be in overall charge of equality, diversity and inclusion at the IRC. Similarly, if you asked staff who is responsible for Health & Safety, I believe staff would say the Health & Safety Manager, even though everyone has their individual duty to take care of their own health and safety and that of others who may be affected by your actions at work.

112. At document CJS004281_5, it is recognised that the Shaw review had issues with Brook House's translation services, and issues were to be reported to me. As a result of these staff complaints, Brook House switched translation service providers from Language Line to The Big Word. I believe that The Big Word's translation service was a lot better in terms of being able to connect to a translator and receiving a more professional service, albeit it was still not excellent. I say this because it was sometimes difficult to get hold of translators for certain languages during the night. Also, you would sometimes find that because the translators were "on call", which meant that you could be connected to them when they were out shopping, and this was distracting. However, other than these points, The Big Word is still a big improvement compared to Language Line in many ways.

113. With regards to a medical language line, when G4S was still in charge, everyone could access translation services by using an area code that was specific to the department at which they were based at the time. (I believe this provider was Big Word). So, the Healthcare Department at both Brook and Tinsley House had several department codes which were used to identify where the call were coming from. Since Serco took over, Tinsley House has one code (area code) and Brook House has another (area code) to access The Bigword. These codes only show the calls as originating from the centre and do not show the specific department calling. External agencies such as the current Healthcare provider, Practice Plus, have their own processes and supplier in place.

Role as workplace colleague

114. As part of my role as a 'workplace colleague', I am required to attend disciplinary hearings or investigations into a grievance. My role during these meetings entails supporting the individual who is subject to the hearing or investigation, asking

for an adjournment where required or speaking on their behalf to ask questions or to put forward their case in response to the allegations made against them.

115. The Inquiry has asked me to consider a number of transcripts of meetings which I attended as a workplace colleague (documents CJS005907, CJS0073014, CJS0073613 and CJS0073524). It is noted that document CJS0073565 is also referred to in the question set, however, this transcript has not been provided by the Inquiry. I am therefore unable to comment upon this meeting.

116. Having considered the transcripts provided, they look to be a contemporaneous note and I therefore have no reason to believe they are not an accurate representation of what was said.

117. From my own recollection and having reviewed the transcripts provided, I personally do not believe that these investigations were carried out fairly and appropriately. I recall that there were problems with witness statements and interview notes going missing and/or not being disclosed to the person being investigated. I also felt as if statements provided by other staff members were not recorded accurately, or were mere opinions and lacked evidence to support/prove their assertions. Yet these witness statements were treated as concrete evidence without further investigation.

118. Similar to the above, I did not feel as if the investigations were thorough enough. It was more of a case of "we believe that this is happening, so it must be happening". Even when there was little to no supporting evidence, the investigation report was written in a manner that made it seem that such evidence was available and the allegations were substantiated. As such, when the report was submitted to the Home Office, the Home Office had no choice but to withdraw the employee's clearance. Without clearance, an employee is unable to work in an IRC and was therefore sacked.

119. This process also removed G4S from any blame in the matter, because it was ultimately the Home Office's decision to remove clearance.

120. At times I also felt as if there was an attempt to prevent staff from asking me to attend meetings as a workplace colleague. Sometimes I was unable to attend these

meetings because I had prior arrangements and the meetings were not rescheduled when in my view, they should have been. In the event that I was unable to attend a meeting as a workplace colleague, I would advise the staff member to take someone else instead, such as a union representative. This way, just because I was not available, it did not necessarily mean that the staff member has to attend the meeting alone.

121. Certain transcripts provided by the Inquiry also demonstrate that on multiple occasions, there were attempts to prevent me from addressing the hearing on the employee's behalf.

122. Document CJS005907_22-23 records the concerns that I raised over the fact that DCO Babatunde Fagbo was not shown the complaints that were the subject of his investigation meeting that meeting took place in mid-2017.

123. In so far as I was aware, it was not the standard practice that interviewees were shown complaints before an investigation interview. This would also not be practical. I recall that the reason for my concerns on this occasion was because DCO Fagbo had asked why he was being investigated and he was not given any information in response. He therefore had no idea prior to the meeting what it related to.

124. I cannot recall whether I had concerns about the fairness of the investigation meeting for DCO Fagbo. Although I do believe that a person has the right to know the case against them before being questioned on it and should be given the opportunity to challenge the accusations. In my eyes, denying an individual this right is not fair.

Use of Force

125. I have reviewed document HOM002677_2 which relates to the use of fish knives.

126. I can confirm that there was no specific refresher training course for Big Fish Safety Knives during the relevant period. The annual staff refresher training did,

however, run through safer custody requirements that may have touched upon Safety knives.

127. I believe that everyone in a detainee-facing role should carry a fish knife.
128. All staff issued with a fish knife have to sign an agreement which gives instructions on the use of the knife. We used to keep a log of staff members who had signed this agreement. I am not aware whether the Safer Community Team still keeps any such logs.
129. The Inquiry has asked me to consider documents IMB000067 and IMB000074, which are Use of Force Scrutiny Meetings minutes that I attended. I personally tried to attend every use of force scrutiny meeting that I was invited to, which, I believe started following Panorama. After some time, I stopped attending these meeting as the SMT decided that it was not necessary to have us there and I cannot recall at what stage the meeting stopped happening in that capacity.
130. The Use of Force Scrutiny Meetings were used to discuss any matters of concern and have oversight of Use of Force interventions. My role during these meetings included scrutinising previous Use of Force events, contributing to discussions and asking questions relating to Use of Force.

Abuse behaviour towards staff

131. I have been asked to consider a number of emails chains relating to abusive behaviour towards staff (documents CJS005230_7, CJS004722_5, CJS005000_5, CJS005282_4 and CJS004925_3) and describe the actions that I would have taken even though I was not directly asked to do anything.
132. In such circumstances, where I was not directly asked to take action, I would still have oversight of the matters and would check with the team that everything had been completed as required or if anything remained outstanding.

133. Take document CJS005230_7, for example, where the email is directed at M. Eggerton to action, who was the Safer Community Manager at that time. I would still make enquires to make sure that someone had picked up the email and it was being actioned.
134. Document CJS004963_5 records that I was asked to speak with D1103 who had been making homophobic comments to staff. Due to the passage of time, I cannot remember what I would have said to D1103 about this. Nevertheless, following an incident of this nature, I believe that I would have reviewed the detainee's room sharing risk assessment and advised staff to issue the detainee in question with a formal warning if not already done so. It is the responsibility of the staff member(s) involved in the incident to issue a warning if they deemed it to be warranted.
135. If a detainee's poor behaviour continues following a warning, or there are repeated incidents, the only other sanction available to staff members is to place the detainee on Rule 40. However, Rule 40 is rarely adopted as it requires a lot of justification and is not necessarily there to sanction abusive behaviour towards staff. And in any event, if a resident is placed on Rule 40, then 9 times out of 10, they will be back in association the next morning, so it does not really achieve a lot. I do think that this is frustrating for staff at times.
136. Prior to Steven Shaw's review, if a detainee was given more than 3 warnings within a certain time period, they would be placed on a 'basic regime'. This scheme was taken from the Prison system and meant that a detainee's privileges would be completely stripped back. However, a recommendation for Steven Shaw's review was that this process should only be used in Prison environments and, as such, this system was stopped about 4/5 months after the report was published.
137. Document CJS004723_5 records that I was asked to speak to D1913 who had called DCO Opoku racist because he would not give D1913 food before unlock. I cannot recall whether I deemed this action to be racist or not. During this time, it was policy that detainees should not be given food before unlock. However, I am aware that certain wings relaxed this rule from time to time and used their discretion for some

detainees who was already unlocked for their duties/paid activity. I also cannot remember what I said to D1913 in relation to this incident and allegation. With regards to what action I would have taken in such a scenario, besides speaking to the detainee in question, I would have made sure that the detainee was aware that they were processes available for them to submit a formal complaint if they believed it was necessary. I also would have spoken to the member of staff involved to find out as much as I could about what happened.

138. As with all the residents I am asked to speak to, I normally record a note of the visit, along with their details. Sometimes this is copied from any response sent back to security. I would keep all of my notes on my computer. If a visit recorded a certain type of complaint, such as allegations of homophobic or racist discrimination or issues relating to disabilities, then I would print hard copies of these notes and store them in physical files. These records were purely for my own use and for me to refer back to.
139. The inquiry has asked me to consider document CJS004944_2, which relates to an incident that took place on 21 May 2017 where D484 was verbally abusive towards DCO Hoque when the detainee was denied access to another wing, which it is said that I witnessed. I cannot recall this occasion specifically, however it is possible that I did witness this incident. Throughout my time working at Brook House, I have seen numerous incidents where detainees have forcefully tried to gain entry to another wing and access that they are not allowed into.
140. With regards to whether I completed an incident report for this incident, I cannot recall witnessing this specific incident and the staff member affected would have been expected to complete the required report.
141. For clarification, it is the responsibility of the staff member(s) directly involved with the incident to complete an Incident Report. If you were simply a witness to the incident, then you may be asked to complete a witness statement to assist with an investigation should one be required. For other issues where you observe and or witness something that gave you concern then you would submit an SIR.

142. Documents CJS004853 and CJS004683 relate to an incident where D3265 racially abused DCO Babatunde Fagbo. It is understood that DCO Fagbo submitted an SIR late. I cannot recall why DCO Fagbo did not complete an SIR prior to speaking to me.

143. In terms of how I evaluated the veracity of DCO Fagbo's evidence, I am always aware that there are two opposing sides to any complaint and I cannot only take the word of one person to determine what happened. I cannot recall what prompted me to go and speak with all parties involved to ascertain the extent of their involvement and work out what happened. This is a common step to take when trying to understand an incident.

Bullying

144. The inquiry has provided a number of documents that relate to submissions of SIRs for bullying. The documents record emails that relate to allegations of bullying and which were sent to me following receipt of such SIRs, however, the emails do not direct me to take any particular steps (documents CJ S004690_5, CJ S004983_5, CJS005147_7, CJS005167_5, CJ S005305_5, CJS005410_5 and CJS005391_7).

145. According to DCM Caz Dance-Jones (document VER000220_7-8), I was copied into these emails relating to allegations of bullying submitted so that I was aware that the appropriate DCM had received the information in order to complete an investigation. From my memory, it was a requirement of the Monitor, Challenge and Support process ("MCS"), for the Unit DCM to carry out the investigation and follow through with the necessary actions where required. This could be placing the detainee accused of bullying on a Monitor Challenge Book or placing the detainee that has been subject to bullying on a Monitor Support Document, both of these actions would have followed the resulting bullying investigation. There was also an associated requirement for the Safer Community Team to be made aware of any allegations and for associated investigations into the allegations be monitored by the Safer Community Manager as part of the Violence Reduction Strategy. This included checking that investigations were being carried out when required and were being conducted properly.

146. However, as previously stated there were only two of us in the Safer Community Team who worked shifts, and as such, it was the responsibility of the Unit Managers to manage the units and we would monitor, and highlight any trends to help put measures in place.
147. With regards to what steps I would take following receipt of the type of emails mentioned above, I would check that an investigation has been opened and completed where required and any necessary actions were put in place.
148. I have considered document CJS004644, which records that D2294 and D1074 were referred to me for 'Safer Custody'. A referral to Safer Custody consists of a referral from staff about a detainee they have concerns about.
149. Once a detainee has been referred, I would go and find the individual and have a conversation to see what exactly is happening, what the issues are, where they feel safe and what they would like to happen. I would also activate any appropriate support mechanisms that were available to use at the time, depending on what was discussed and raised by the detainee. For example, if the detainee had been subject to bullying, then I would open a Monitor Support Document. Or if I considered a detainee to be at risk, I could complete a Safer Detention Referral for transfer if the person would like this and if it was deemed necessary for their safety. We had various tools available to us, it just depended on the circumstances of the detainee as to which route was taken.
150. Document CJS0073895 records that a bullying investigation was not completed after a detainee on detainee assault "as there was no previous bullying known of before the incident and none noted from D1467 during Conway's interactions with the four of them". This is because there is a threshold that must be passed before the requirement to conduct a bullying investigation is triggered.
151. This threshold includes amongst other points, repetitive, intentional behaviour or if the matter involves an imbalance of power. This may be, for example, an imbalance of power in terms of detainees' size or age, whether a detainee had a serving job which meant they were able to abuse this power by giving another detainee less food, or if one of the detainees was in a gang, as there was a problem with gang culture at the centre.

152. I cannot recall the meeting described in document CJS0073895. However, as per James Begg's explanation, the individuals were in the CSU and as such, it would not serve any purpose for them to be placed on a bullying Monitor Challenge Book. Once the individuals were back on association, where they could be monitored. This was because the purpose of a Monitor Challenge Book is to monitor the detainee's behaviour towards other detainees in association. Whereas a detainee is in isolation in CSU, so there would be nothing to monitor. Secondly, a Monitor Challenge Book can only be opened for 14 days, so if you opened the document whilst the detainee was in CSU, you would waste valuable days monitoring them in association. Therefore, it is much better practice to open the document as soon as the detainee is back in association.

Incident Reports

153. I have considered documents CJS005276_5 and CJS005180_6. The Safer Community Manager, M Eggerton, describes the action that I would take following receipt of emails containing notifications that a Safer Community orderly was involved in an incident. For context, a Safer Community orderly is a detainee that is allowed to access all wings in the centre to speak to residents freely about any concerns they may have about safety. The orderly is then invited to attend meetings with the Safer Community Team to feedback any issues and discuss matters. The orderlies are paid for this work and are also provided with burgundy t-shirts to wear so they are easily identifiable to detainees.
154. I have reviewed document CJS004856_3 and 5. The SIR states that "Safer Community to be made aware of these allegations for their information. To be monitored via ACDT process" and the email notifies me that D1077 claims he swallowed a razor blade. In such circumstances, if the individual is currently being supported through the ACDT process and has had an emergency case review following the crisis point, there is nothing further that I can do, except for carrying out a case review. However, all managers are trained to carry out a case review, so there would be little to no need for me to do this myself.

155. Documents CJS000893 and CJS005511 relate to an incident involving D2034. I can confirm that walking someone down to E wing does not entail any use of force.
156. Constant supervision involves a staff member constantly observing a detainee and as a good practice being at a distance of no more than 4 to 6 feet away from the detainee. This is referred to as a "safe reactive distance". Despite a detainee being under constant supervision, there is a risk that they may still be able to self-harm. Unfortunately, this has happened previously and will continue to happen because the staff member observing the person may be a number of feet away from the detainee going through a crisis period. As such, by time the staff member has time to react and intervene, the detainee can cause harm to themselves. This is why we asked staff to be vigilant and rotate as much as possible to mitigate the risk of staff becoming complacent.
157. The Inquiry understands that D2034 self-harmed while on constant supervision after making comments that he will kill himself if he does not get a single room on D wing. I have been asked to explain why this case was a "NFA" and the SIR closed.
158. I don't believe the NFA is in relation to the person being allocated a single room but the steps in escorting the person to Eden Wing and placing him on constant supervision. There is a separate process for reviewing whether a detainee should be in a single occupancy room. This process involves a review of the detainee's Room Sharing Risk Assessment ("RSRA") and depending on the outcome of the review, the detainee may be granted single occupancy. All assessments with regards to single occupancy requests must be recorded and justifications for the conclusions reached must be clearly stated. The Security Team lead this process, in conjunction with Healthcare and Safer Community.
159. I have been referred to CJS005512_6 which records that I was emailed with a request to refer D2294 to Safer Custody. In response, I confirmed that I would see the detainee at some point. It is not necessary for the Safer Community Team to see the Detainee to make a Safer Detention Referral. However, seeing the person tends to give a better picture and understanding of their concerns.

160. In terms of any requirements of time for seeing a detained person following a referral request, these visits should be completed as soon as possible and within the first 24 hours from the referral. For the majority of matters, a visit would be completed within the first 12 hours. However, as mentioned above, there were only two of us working in the Safer Community Team. This coupled with the low staffing levels meant that if one of us was either on holiday or off work for another reason, it may not have always been possible to cover shifts. Additionally, both the Safer Community Manager and I had to deliver training as part of our roles, his two (2) full days and I one (1) full day. It therefore meant that on occasions there was not always somebody in every day to visit detainees following a referral request. As such, some responses were not as quick as we would have liked them to be but most were still dealt with within 12 hours.
161. As far as I am aware the salary that was down to cover the other post in the Team was used as part of the uplift to recruit the additional Welfare officers.
162. The purpose of seeing D2294 in circumstances where he may have already moved to Tinsley was to find out how he may be getting on, any issues and or concerns he may have that we can assist with.
163. I have reviewed document CJS005526_4-5. I can confirm that I have never acted as ACDT Co-Ordinator. As stated in the review of his DAT entry, the case review was carried out by the Safer Community Manager.
164. If I was ever notified that there is a risk of a detained person hurting themselves, should they be served removal directions or be taken to their flight, I would aim to support that detainee through the ACDT process.
165. The notifications contained within documents CJS0072787 and CJS005479_5 were sent to a number of individuals due to the uncertainty with staff arrangements and knowing who would be on shift to assist with the matter. I would have expected the staff members who were on shift at the time of receiving these notifications to have opened an ACDT for the detainee in question. I myself cannot recall taking any specific action in response to these two notifications.

166. You could easily tell when a notification had been actioned because there was an automatic email that was sent round to all parties confirming when a document had been opened in response to a notification and by who. This way, everyone was able to monitor what notifications had been actioned and follow up on those that had not been picked up, in relation to ACDTs.

167. I have been asked to consider row 267 of the BH IR Log at document CJS000896. I cannot specifically recall whether I was the officer who separated the detained persons punching each other and or the Manager who placed them on Rule 40. It could possibly have been me, but I cannot confirm this. I may have placed the individuals on Rule 40 for fighting and/or completed the associated paperwork. Either way, my direct involvement would have been recorded on any accompanying reports.

Drugs

168. The inquiry has referred to me document CJS004831_2, an SIR completed by James Begg. Apparently, when I was told that D2019 had smoked "some ganga, weed", I responded with "well if there is nothing I can do to help, I need to be getting on with some work" and then left.

169. Firstly, I would like to confirm that I do not recall this conversation taking place as it has been described by James. I do not believe that I would have responded in the manner alleged if I had been told that a detainee was in the possession of weed and had just smoked it. I do appreciate that every individual perceives an incident differently and this may lead to inaccurate recollections of previous interaction.

170. Normally, if I discovered that a detainee had smoked ganga or weed or taken another illicit substance, depending on the health and state of the detainee, on discovering such case that they had taken the substance, call for Healthcare staff to attend and or I may also take them to Healthcare for assistance or for a health check. In all cases where banned substances had been taken or found on a detainee, I would have completed an SIR to report the incident. Try and ascertain where they had got the substance from, then I would have searched the detainee and or room to confiscate the banned items.

171. I personally believe that would have said something along the lines of "is there anything we can do for you", as at that point, I was stepping in as the detainee was squaring up to James. Further, I would not normally tell detainees I have work to do.
172. As mentioned above, if a resident appears to be genuinely under the influence of drugs, then I would have submitted an SIR. The SIR may have led to an investigation to find the source of D2019's drugs.
173. I cannot recall whether I completed a corresponding incident report about this event. I am confident, however, that my decision as to whether or not I submitted an Incident Report would have been based upon whether I thought the report of drug use was genuine. I.e., it was a true report and was not fabricated.
174. I have been asked to review the email chain at CJS005460_5 and comment upon any actions I would have taken following receipt of this email. However, I am not sure whether this email chain would have come to me. I would not have expected it to come to me as Diversity Race Relations Manager unless I was covering a wing for that day.
175. I have considered the email chain at HOM018743_13. I cannot recall specific incidents where detained persons were threatening others over spice related issues, but I do remember there being Safer Detention Referrals being sent in that regard.
176. Similar to the above, I cannot remember how often requests for a transfer out of Brook House were made for those fearing their safety due to owing money for spice.
177. The inquiry has asked me to consider CJS004642_7, regarding an SIR which stated that D1275 appeared to be being used as a "guinea pig" to try out drugs being trafficked in, and commented on how common a problem it was for detained persons to be used to trial drugs. I do not believe that I am best placed to comment upon the frequency of this. The Security Team would be best placed to answer this question for the Inquiry.

Adults at Risk

178. It is noted in VER000273_3 that I chaired Adult at Risk ("AAR") Multi-Disciplinary Teams ("MDT") meetings. This is incorrect. These meetings are chaired by the Head of Safeguarding. The Safer Community Manager and I may step in to chair these meetings should the Head of Safeguarding be unable to attend the meeting or if they are running late, may start the meeting on their instruction. A number of people have held the roles as Head of Safeguarding and the Safer Community Manager, I therefore cannot remember who was specifically in these role at that time.

179. I can confirm that the weekly meetings referred to in document VER000224_17 are the AAR MDT meetings. The purpose of these meetings was to review AAR currently at the centre as per DSO 08/2016 and look at what is in place for those detainees at Level 2 and 3, concentrating on their release/discharge from the centre.

180. For context, during the Relevant Period, detainees could be classified as 'Level 1', 'Level 2' or 'Level 3' by the centre depending on the extent to which they were deemed to be at risk or vulnerable for various reasons. The classification of a detainee (if any) entitled them to receive additional support and oversight. Level 3 is the most serious level and was reserved for the most vulnerable detainees. The type of risks that detainees were categorised against involved medical issues, bullying, self-harm etc.

181. The inquiry has informed me that MHN Churcher considered that the sharing of information regarding detained persons has improved due to these AAR MDT meetings. I would agree with this assessment. This is because Healthcare started to share information with us about detainees. We found that detainees tended to open up to Healthcare staff members and as a result gave them a lot more information compared to what they told DCO at reception and on their allocated wings. This information was invaluable for highlighting vulnerable detainees that were not forthcoming or identifying additional issue points. However, at some point, the AAR Manager considerably limited the information that Healthcare could share with the AAR MDT. Personally, I found that the AAR MDT meetings were most helpful when we had this free flow of information from Healthcare. However, it is important to note that I am no

longer involved in these meetings as I have since moved roles. So I am unable to comment on present practices.

182. I am unable to comment in great detail upon whether there was a marked change in the use of Supported Living Plans ("SLPs") for detained persons after the introduction of the new DSO on AAR. However, since the SLP documents was introduced at Gatwick in 2014, the number of SLPs increased every year.

183. I have reviewed Kate Lampard and Ed Marsden's comments made in response to an AAR meeting that I chaired and they attended (document VER000237_6). From my recollection, Kate Lampard and Ed Marsden arrived late to this meeting. So I am not surprised that they found the meeting hard to follow and did not understand what was happening. I believe this is why they returned to a further meeting a second time.

184. With regards to their claim that the meeting did not have a beginning, middle and or end, this is simply not true. The meeting would have begun with a review of the minutes from the previous meeting and followed the terms of reference and/or set agenda.

185. With regards to the comment that states "two of our recommendations [in our annual report] were around [...] better working of the multidisciplinary teams, whether it's adults at risk or it's just people with complex issues. Particularly for release because sometimes it just seems a surprise when somebody is about to be released and there aren't plans in place", I believe that this is a comment from the IMB and relates to recommendations that the IMB had made. I understand this and felt it would be excellent if we all had the prior knowledge days in advance, but this was never the case. The Home Office tended to inform us that a detainee was being released a few hours before they were scheduled to leave.

186. With regards to Mr Marsden's comments at page 8 that I lacked the skills of somebody used to chairing meetings, I do not believe that you can make such comments based on a 15-minute encounter and I do not feel his comments are valid and lacked substance. This is not an accurate representation of my ability. I also believe that Mr

Marsden made the assumption that chairing these meetings was my main role at the centre.

Supported Living Plans

187. I have been referred to document CJS000507, which is the Policy on SLPs that I wrote in June 2016 and amended in May 2017. I cannot recall exactly how this policy was shared with staff at that time. However, I believe that it would have been done in accordance with the training policy.
188. In so far as I am aware, staff are familiar and confident with the process of setting up SLPs for detained persons. There was a definite increase in their usage over the years.
189. Document VER000224_6 records a comment I made where even if I did not believe that detained person is vulnerable when they are saying they are, I would still treat them as being vulnerable, and consider if support mechanisms needed to be in place, or any reasonable adjustments should be made.
190. In these circumstances, I would take what the detainee was saying seriously and support them through the formal policy and supporting procedure in place.
191. I do believe that this practice was also followed by other staff members at Gatwick. Personally, I think that staff have done some excellent work in supporting detainees going through periods of crisis.
192. I have been asked to consider document CJS002661 which relates to the SLP for D2019 that I activated on 28 April 2017. This lasted until D2019's departure on 4 May 2017. Reviews of this SLP were undertaken in accordance with the SLP Policy. The review of SLPs consisted of a multidisciplinary approach.

ACDT

193. Documents CJS003032_9 and CJS002886_9 are examples of ACDT 'on' or 'off' notification forms from April 2017 within which I am listed as having received a copy. I am not sure why I was added to the email alias to receive these notifications as these forms had nothing to do with my role at the time. I believe that the notifications were only used by the Safer Detention Manager to keep them in the loop of all ACDTs that were being opened and also to compile a report at the end of each month. The others on the mailing list had their own use for the document.
194. Document CJS004776_7 records that I was asked to speak to Nat Thomas to ensure she was aware of the process of opening an ACDT. I can confirm that I do not recall receiving any such instruction. I therefore do not recall speaking with Nat Thomas in relation to the process of opening an ACDT.
195. The inquiry has directed me Sarah Walpole's interview with Dominic Aitken (document IN0000076_2), within which Sarah comments that she did not receive training on ACDTs, and did not know she could open one until speaking to another teacher. I can confirm that training provided on ACDTs was carried out by the Safer Detention Manager. I did not take any part in this training, other than attending my refresher training as all staff are equally required to do.
196. I have reviewed document CJS005396_5 where I raise a concern that staff are submitting SIRs about detained persons rather than opening ACDTs, and I ask for refresher training on this. In this regard, although staff were trained on the uses of ACDTs during the ITC, staff would have benefited from further practical guidance when going through the process of opening an ACDT for the first few times.
197. After I had raised my concerns, the ACDT process was included as part of the suicide and self-harm ("SASH") section of the refresher training, this involved staff being allowed to use blank documents to practice on.
198. I have considered Steve Skitt's opinion that the ACDT process was overused, and that too many detained persons were being placed on constant watch unnecessarily (document IN0000077_2). In my view, I think that the multi-disciplinary case review team is well within their right to place a detainee on constant supervision if they feel it

is warranted regardless of how many other detainees are already enrolled on the process. I do not think the process was overused.

199. The inquiry has directed me towards DCM James Begg's comment in his interview (document VER000279_13) that Safer Community were doing well until he and Michelle Brown moved. When it comes to the safe guarding of detainees, I do believe that it is important to appoint managers that have a passion about safeguarding detainees. Individuals should not just accept a managerial role in safeguarding for the title or financial incentives. If they do not truly care about the welfare and safety of detainees, then this will shine through in the teams' success and will eventually have a negative effect on the team, which I feel has happened in the past. However, it is important to note that this is not a comment about my current experience as I am not working in this department anymore and am unable to comment on the current situation

200. I have reviewed document HOM003036_11, where I chaired the case review for D1527 on 25 May 2017. The decision-making process for this review consisted of a summary of prior events, a discussion surrounding why his observation should remain at that frequency, and consideration of the ACDT guidance on page 6 of the version of document we were using at the time, 'suicide/self-harm risk guidance.' In this case, the detainee concerned was on Hourly Observation which in itself was already high and if we follow the guidance as detailed in the ACDT document, as the team, he was on the correct observation at that time.

201. Document TRN0000101_3-5 records DCO Callum Tulley talking to a male manager (who he refers to as "Ah Conway" and later thanks as "cheers Conway") regarding the opening of an ACDT for a detained person in room 201. I am unable to recall whether I am the 'male manager' referred to in this transcript. Given that DCO Tulley says "Conway", it is likely that it may be me as I don't know of another Conway at Brook House, but I cannot confirm this as the transcript does not read in a manner that I believe I would speak; it reads to me as if there are parts of the transcript missing.

202. The transcript continues to record the unknown male manager as saying that an ACDT does not need to be opened just because a person says that the place makes them

feel like dying. Rather, it only needs to be opened where you feel that the person will harm themselves.

203. From reading the transcript, I do not think that this male manager was saying that the detainee should not be considered as being 'at risk', but rather the manager is trying to understand what the DCO is feeling about the conversation they had with the detainee. Whether an ACDT should be opened should be a decision made by the staff member directly involved with the detainee as they will have better insight into the tone, context behind and manner in which something was said or done. I do appreciate that there is an element of subjectivity here. Therefore, with the case referenced in the transcript, I believe this is an attempt to get the DCO to determine whether they feel as if the detainee needs additional support because they are at risk of harming themselves. It is not always the case that managers are available to speak with and check the appropriate course of action. In these scenarios, it is acceptable to open an ACDT to be on the safe side. The ACDT can always be closed if a case reviewing team thinks that it is not warranted upon review. It is encouraged that staff members can open an ACDT without the fear of being made to look silly.

204. It is down to every member of staff who has a concern relating to detainee/s to raise it via the appropriate channels. Everyone has a duty of care towards detainees and it cannot be always left to a manager.

205. I am not sure whether this is made clear to staff members during ADCT training. Likewise, I am not aware of whether all staff are aware of this distinction from conversations with managers. Unless staff are explicitly told, you cannot expect them to be aware.

206. The inquiry has asked me to comment upon James Begg's opinion of ACDTs at Brook House (contained in document VER000279_14-15). In my view, the opinion that DCMs did not take ownership of ACDTs that they were case managers for heavily depended on shifts patterns. It was not uncommon for DCMs to be set as case managers on days when they were not on shift because it looked as if they had the most capacity that day on the system. This became apparent when we as the Safer Community Team

were carrying out document checks. I recall that this was reported to the Head of Safeguarding at the time.

207. I have considered the case reviews in documents CJS002551_17, CJS002667_18 and CJS002083_20 that I chaired, albeit it was not listed as the case manager for these detained persons. I do not think that these detainees were disadvantaged by the fact that their case manager was not in attendance for the review.

208. A detainee can have a Case Manager and yet never actually see them because of the way in which working shifts fall. The outcome of all case reviews is shared across all DCMs to pick up as part of their day and/or Unit they are allocated to for that day.

209. I do believe that case reviews can be extremely advantageous for detainees if the team takes the time to listen, follow-up on the issues raised and make the right referrals. On some occasions, it may have been the case that follow-up points were listed but were not necessarily actioned. However, I do find it difficult to recall what was happening back in 2017 so do not feel as I can comment further than this.

Complaints

210. I have reviewed document VER000224_12 within which I explain that if any officer receives two or three complaints, then there would be a need to take a wider look at why people are making complaints about them. I personally am not directly involved in this wider investigation. This process is normally triggered following instructions from the SMT.

211. The Inquiry has provided me with a number of documents that relate to complaints that I investigated (documents CJS005911, HOM005397, HOM005399 and CJS001570). I have been asked to comment upon if there is anything I would have done differently.

212. I believe all the complaints I investigated were completed fully and any response that was given was fully supported by evidence to show why I had come to

that particular decision. Having a feeling that someone is racist is one thing but being able to support this with evidence is another. If you cannot support it, it will remain just that, a feeling. It would not be right to uphold a complaint without the evidence to support it.

213. There are always things that can be better, but I am confident with the decisions that I reached in all of these investigations. Some of my completed investigations were also subject to the 10% check from the SMT. For this, the SMT randomly selected 10% of complaints that contained elements of potential racial discrimination to review how the complaint was handled. This happened in addition to the standard process where your proposed response was sent to the SMT for approval. I therefore do not think that I would do anything differently if I were to investigate these complaints again. I am not sure whether the SMT still check 10% of complaints at present because I am not in the role any longer.

214. I have been asked to review my response given to a complaint regarding a visitor's treatment by DCO Mark Earl (document CJS005905). Unfortunately, some of these complaint responses were sent with sections and or parts missing. Having read the complaint response, it does not appear to flow from one section to the next.

215. A number of complaint responses that were sent to the complaints clerk as unsubstantiated had been edited to lower the word count. These complaints were sent to the SMT and complaints clerk before being sent to the complainant.

216. I first realised that my complaint response reports were being edited to reduce the word count when I received a 10% audit check from the Home Office. As part of the audit, the Home Office had reviewed a complaint that had been withdrawn by the resident, but I still investigated in line with the policy in place at that time. Nina Carma from the Home Office informed me that she reviewed this complaint and had noticed that there was a significant section of the complaint response missing, including wording relating to the investigation outcome and my comments detailing the investigation process that I had followed. I remember that I was astonished when I found out the document had been edited and words have been cut. I recall that I resent a copy of the original complaint response that I had prepared to the Home Office

(forwarded original email with attachment) for them to review instead of the edited version. However, I was told by the Home Office that they can only audit the version of the response that was sent to the detainee, which in this case, was the edited version.

217. Following this, once a complaint was edited it had to be shared back with the person who investigated it to confirm if they are happy with any amendments made to the response.

218. All of the originals to my investigation can be found in the boxes, currently being held by G4S I believe, all went to storage, if they are not with the Inquiry Team.

219. I have considered documents CJS001400 and CJS001443. Unfortunately, in this matter, there was not enough supporting evidence to substantiate any complaints.

220. Having reviewed document CJS001425_6 and 12, I do not believe that four welfare officers are sufficient for the needs of detained persons. I have always been of the opinion that the Welfare Team should consist of a minimum of eight officers and should operate from the moment a detainee arrives.

221. Having visited Colnbrook in 2016 and seeing their Welfare Team in operation, I felt our two-officer operation was seriously lacking, in both terms of officers and facilities provided. And on return to Gatwick, Michelle Brown had submitted plans to increase the facilities staff had access to, these including Fax machines, scanners and others.

222. I am aware that following the complaint in document CJS001425, it was agreed that two more detainee welfare orderlies would be recruited. This did assist to a tiny extent with the strain for welfare resources. However, an orderly is only capable of assisting with a set number of things and detainees were still unable to access what they wanted help with. Welfare orderlies are detainees that are paid to provide assistance to other detainees, working with the Welfare Officers. For example, Welfare orderlies provides detainees with a numbered ticket if they want to speak with the Welfare Team during the drop-in hours. The detainees then have to wait until their number is called to speak with a member of the welfare team. Although, I am aware that at present,

orderlies have been stopped from accessing other wings due to Covid-19 restrictions in place at the centre.

223. I have been asked to consider a number of documents that relate to complaints that were sent to the PSU to investigate (documents CJS001549, CJS001403_33-36 and CJS001360). I do not normally have any involvement in deciding whether complaints should be referred to the PSU.

224. During the Relevant Period, all complaints that were raised by detainees were submitted to the Home Office. The Home Office would then determine whether the complaint should be investigated by the PSU or the IRC concerned. Some complaints were also submitted to the IMB.

225. Complaints are normally sent to PSU before they are sent to me. It may be that they determine that the complaint should be sent back to be investigated in house, but these can always be escalated back to PSU if evidence is found to support the claim and where we feel it is warranted.

226. So, in a sense, the severity of the complaint determined by detention services will normally dictate where their complaint go first, at which case we may be made aware of the complaint, but knows it is/will be investigated by PSU.

227. I do not believe that it is very common for me to be allocated cases that subsequently require referral to PSU. I also do not recall being made aware of the fact that the complaints referred to by the inquiry were sent to PSU. However, I would welcome any input from the PSU.

228. I have reviewed document CJS0073683_4 which records that Tamzine McMillan approached me regarding the investigation of her complaint against another member of staff, but I can confirm that I did not know anything about this complaint at the time. Complaints submitted in this manner are normally investigated by a member of the SMT.

229. With regards to any steps I took to assist Tamzine McMillan in her complaint, Complaints are private and confidential and once they are being investigated should not be discussed by other staff.

Statement of Truth	
<p>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.</p> <p>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.</p>	
Name	Conway Edwards
Signature	Signature
Date	15/03/2022