BROOK HOUSE INQUIRY

Witness Statement of Mr Stephen Skitt

I, Stephen Skitt (D.O.B 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 16 September 2021 (**'Rule 9 Questions'**).

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.

Background

3) I have worked in the custodial industry for 35 years. For 25 years of this, I was based in Her Majesty's Prison and Probation Service (**'HMPPS'**), 9 years of this was with G4S and the remainder has been with SERCO on the Gatwick Contract since they took over in May 2020.

4) Throughout my working life I have held the roles of Prisoner Officer, Senior Officer, Principal Officer, Governor Grade, Head of Security, Head of Safer Custody, Head of Residence, Deputy Governor, Deputy Director and AD Security Gatwick IRC.

5) I was TUPED from the Prison Service to G4S in 2011 as part of the privatisation of HMP Birmingham as Head of Security. In or around autumn 2014, I was asked to assist with an internal investigation at HMP Altcourse and therefore I moved into a temporary Head of Security role at HMP Altcourse.

6) In or around May 2015, I was asked by G4S to go to Gatwick Immigration Removal Centre (**'IRC'**) because there had been historical difficulties, involving many grievances, at Senior Management Team (**'SMT'**) level. I was therefore seconded to Gatwick IRC to support the SMT in the capacity of Head of Security and to provide some stability in the security area of the centre as Wayne Debman (**'Wayne'**), Head of Security and Safety, left the business. I was aware that there were a number of ongoing complaints against Wayne when I joined. At the time I arrived at Brook House, Ben Saunders was the Director.

7) I cannot recall how long this secondment was due to last, however, in or around August 2015, I applied for the role of Deputy Director at Gatwick IRC and was successful. I decided to apply for a role at Gatwick IRC because I thought it would be a good challenge and I like to move around and try new things.

8) I was Deputy Director at Brook House during the Relevant Period. In this role I was responsible for day to day operations and oversight of the functional heads who reported to me. I also looked after certain areas such as Safer Custody. I would have a meeting in the morning and tended to get round and visit most of the wings each day. My role involved attending a lot of different meetings and a lot of strategic planning and oversight of the centre during the day. It was a lot more of an administrative role and I would also deal with things like disciplinary meetings. It was an all-encompassing role as I would also make sure the welfare of staff and residents was as it should be. I used to attend staff briefing most mornings by the OSCAR 1.

9) In or around July 2019, an opportunity came up for the Head of Security role at Brook House. At that time, I was nearing retirement age, so I took the decision to step down from my role as Deputy Director to allow someone else to do the job.

10) Serco took over the Home Office contract for Gatwick IRC in May 2020. When I TUPED over I TUPED across in the role of Head of Security. The name of my role changed to Assistant Director under Serco, but this was just a name change and the role remained the same.

11) In January 2022, I moved into the role of AD of Operations which involves managing the day to day operations of Brook House. Within this role I am responsible for operations. Usually when I arrive in the morning I will visit every area of the centre in order to carry out a few checks and sign some documents. I make sure that all of the handovers have been conducted, make sure staffing levels are as they should be and make sure that everything from the previous day has been reported as it should have been. Each day I will also visit anyone who is in segregation. I will generally be attending meetings as a member of the SMT, reviewing Use of Force forms, reviewing footage alongside them and making sure that this documentation is correct.

Professional Qualifications

12) I have no professional or educational qualifications Sensitive/Irrelevant Sensitive/Irrelevant. I have carried out numerous internal training courses in HMPPS suitable for my grades.

Application Process

13) I had worked within HMPPS and a few prisons over the previous 29 years, when an opportunity came up for a secondment. Although being a similar role, working for a different organisation such as the Home Office appealed to me as a professional change working in a different field of work.

14) I was fortunate because I had a general understanding of what the role was within a custodial environment. It would have been the case of getting to know the different

protocols and procedures, which were very similar to those within the prison environment.

15) I mentioned my history of working in custodial environments in my interview with Kate Lampard [**VER000248,** paragraph 7]. The environment within Brook House is similar to places I have previously worked as the actual operation itself on a day-to-day basis is very similar to a prison. There are of course different, and actually fewer, protocols in place because an IRC although by necessity is secure, is not a custodial environment, and rather than having Prison Service instructions you receive Home Office orders.

16) The differences between the prison environment and an IRC are difficult to describe. I did find it different. The core day of an IRC and a prison would be similar, you have open doors, serve the set meals and they have activities, then lock up in the evenings. However, there are many differences, including:

- You do not send the residents of an IRC to work, whereas you would send prisoners to work;

- Within prisons there are a lot more controlled processes in place, for example, incentives and privilege processes. In prison, individuals can earn privileges through demonstrating good behaviour or engaging with sentence management, for example. There is also an adjudications process in prisons which is used as a way to consider and correct poor behaviour When individuals go to prison they know that they can do things to improve their time in there because good behaviour can lead to incentives, but on the flipside if bad behaviour is demonstrated, this can result in privileges being taken away. In the worst cases, prisoners who do not comply with any prison regulations or protocols may be put on a 'basic regime'. Under this regime, a prisoner's privileges will be completely stripped back. This includes, amongst other points removing the TV from their cell, reducing the amount of visits they are allowed or reducing time spent outside of their cell. This ability to reduce privileges gives prisons a greater measure of control over behaviours compared to the IRC environment, where there is no equivalent regime. There are very few mechanisms to control the behaviour

and compliance of detainees within an IRC. I believe there is more of an accountability system in prison which you do not get in an IRC;

- In a prison establishment you are being determined by the Courts and sentences are ordered under the Criminal Justice Act consequent upon the commission of a criminal offence, whereas in the IRC residents are housed as an administration measure as requested by the Home Office; and

- Prisoners know when they are going to be leaving the prison which gives them a degree of certainty whereas detainees in an IRC do not. In my opinion, this uncertainty is very frustrating for detainees who are residing at an IRC.

17) Overall, I think there is more of a focus on free time in an IRC and fewer penalties available. I believed that there were things that could have been done better at the IRC in light of my time in the prison service, as mentioned within my interview with Kate Lampard. Especially given the change in the original parameters of Brook House, which was initially designed to only be a short term holding for detainees [**VER000218,** paragraph 157].

18) In the daily morning meetings, I used to try and instil into staff that there were tools they could use to maintain discipline and control the population of detainees in this environment. A lot of the time it is about how you engage and about how visible and approachable officers are on the wings.

19) It would be fair to say that I made adjustments to my ways of working once I moved to Brook House. Initially, I was a bit out of my comfort zone with certain aspects of the role and had a lack of understanding compared to other more experienced people. When I first started working at Brook House, during the period in which I was settling in, I made sure that I took the time to adapt my ways of working to an IRC environment instead of a prison environment alongside familiarising myself with the different departments and rules. To achieve this, I recall that I spent time talking to various staff members from all departments within the IRC so I could gain a better understanding of

the requirements of the role and the ways of working. Sensitive/Irrelevant I'm more of a practical person rather than a theory person Sensitive/Irrelevant Sensitive/Irrelevant

20) I have been asked by the Inquiry to provide my opinion on whether there was a 'sub-culture' in the prison service where officers 'watch each other's back'. I do not believe 'sub-culture' is the correct word to use. We want officers to be able to support each other. This is an ideal way of working where you are encouraging employees to look after, trust and support each other within the realms of the policies and procedures in place. We wanted everyone to work as a team. This is the same within the IRC.

Deputy Director Role

21) I had no previous experience of being a Deputy Director of an IRC prior to being appointed but I knew what I was going into from the job description. As I have stated previously, the role was to oversee the day to day running of Brook House. There was, and is, a 'Head' of Brook House (which was my title) and a 'Head' of Tinsley House, which was Stacie Dean (**'Stacie'**) when I arrived. The only difference between the two roles was that I would deputise for the Director for both sites if he was not available. This was explained to Kate Lampard during my interview with her [**VER000248,** paragraphs 61-64]. Ben Saunders (**'Ben'**), as Director during the Relevant Period, was more involved with the business side of the centre and I was more involved in the day to day running of the centre. As Deputy Director, I would say that I was more visible to the SMT, staff members and all residents, compared to Ben as Director.

22) The roles of Head of Brook House and Head of Tinsley House became more defined after Sarah Newland (**'Sarah'**) was appointed as Head of Tinsley House. However, I cannot recall exactly when this was. After Sarah was appointed, the only difference (aside from location) in our roles was that I was also appointed as Deputy Director whereas Sarah was not. Sarah would only be involved at Brook House when she was acting as Duty Director, which I believe Sarah explained to Kate Lampard in her interview [**VER000223,** paragraph 6].

23) As Deputy Director, I would have full awareness of any incidents which occurred at Brook House if I was told about them. Incidents were also discussed during morning SMT meetings, which I always attended. As part of these meetings, the Duty Director would provide a full briefing relating any the incidents to the SMT. Here, when I use the word 'incident' I refer to things such as an attempted escape or Use of Force.

24) Looking to Use of Force incidents as an example, I would be notified of such incidents by the Duty Director out of courtesy. This would normally be via an informal conversation to keep me in the loop. The Duty Director would tell me the specific details relating to the incident. The Duty Director would then manage the incident as part of their day to day duties and in accordance with the formal processes in place. In my capacity of Deputy Director I would only become more involved in an incident if the matter became more protracted.

25) I have been asked by the Inquiry to confirm whether I was aware of any incidents taking place in Brook House on the week commencing 15 May 2017. I have specifically been referred to documents **CJS004236**, **CPS000025** and **TRN0000027. CJS004236** is a weekly bulletin showing I was on duty that week, I have been told **CPS000025** are notes made by Callum Tulley, and **TRN0000027** appears to be a conversation between Joe Marshall, Callum Tulley and Dan Lake. I cannot recall any specific incidents the week commencing 15 May 2017 as it was a very long time ago and, unfortunately, none of these documents assist me in recalling any specific incidents that might have occurred that week.

26) I have been asked to comment on an incident which occurred on the 28 November 2017 and Ed Marsden's comment that *"[T]he evidence suggests that the SMT knew about the likely possibility of trouble on the wing before the 28th, and Steve had asked Joules to move [D1159]"*. The Inquiry have informed me that this comment is in document **VER000248** at paragraph 60, however, on review of this document, this is not correct. Having reviewed the other documentation I have been provided with by the Inquiry, I have noted that this comment of Ed Marsden is at paragraph 67 of document

VER000250. I am unable to recall specifically what happened on 28 November 2017 from this document alone. I have a vague recollection of a situation where I asked Juls Williams to move a resident. While I cannot remember specifically why this may have been, I imagine we would have had intelligence telling us that an incident might happen.

27) I cannot recall specific instances of when the SMT were aware of and/or discussed the likely possibilities of trouble occurring within Brook House. However, there would have been some. As an SMT, you always discuss these things as it can be an everyday occurrence. At the end of the day, Brook House houses over 400 people who do not want to be there and therefore we always have to manage any intelligence we receive. I cannot recall any incidents where the SMT were aware of possible trouble at Brook House and did not take any action. But equally, we are talking about a very long time ago and I am unable to pinpoint specific incidents where we did something to prevent an incident based on intelligence.

28) I am unable to comment on whether there was any perception from staff members that nothing was being done to resolve issues or sanction detained persons. I do not recall any staff members saying this to me.

29) Formal debriefs with staff are usually always required following a Use of Force, fire, incidents involving height or loss of power incidents and these are dealt with through the command or contingency process, part of which is a formal debrief straight after the incident. There are also post incident debriefs set up a couple of weeks afterwards. We always check in with any staff involved in incidents such as the above, or informally, to see if they are okay. Staff members have the chance to raise any views they might have at these de-brief meetings, but there are also informal ways for them to check-in.

Head of Security Role

30) I have set out the information I was given about the seconded role of Head of Security and my understanding of the role in paragraph 6) of this statement. In addition, I also

found there to be disagreements between the management structure because of that discussed in paragraph 6).

When I started working at Brook House as acting Deputy Director], I found the IRC a lot more relaxed in comparison to the prisons I have worked in. On an operational basis it is not as challenging as a prison environment. There is, however, more of a challenge with contractual compliance. I say this because you have more autonomy in the prison service compared to an IRC, which must be managed in accordance with the provisions of a contract that is governed by the Home Office. This contract involves KPIs, set contractual standards and procedures which must be adhered to at all times and penalties are applied for non-compliance. An IRC is therefore more demanding in that sense.

31) I have been asked to comment on document **VER000223,** paragraph 244. This document is Sarah's interview with Kate Lampard. Sarah states at paragraph 244 that she had been told by a credible source that I had to be moved out of Birmingham because I was "*on pension rights and it was very expensive*". I do not have a clue what this means and I am unsure as to the intention of these comments or why they were made. I did enjoy higher pension rights when I worked for G4S in Birmingham but as far as I am concerned, in no way did this have any impact on my move to a different contract.

Duty Director

32) The Duty Director would either be onsite or on call for a 24hr period; onsite normally between 08:00hrs -17:00hrs. During that time the Duty Director would be responsible for the daily oversight and management of the IRC. This would include ensuring staffing levels were appropriate and keeping an on-going log of events and responding to any incident. If a serious incident occurred then the Duty Director would initially respond in line with contingency plans. The Duty Director would also be responsible for visiting all areas of the centre checking in with staff, checking all documentation, ACDT, SLPs, PEEPS, Raised concerns etc. Ensuring the regime for residents was operating as per core day. They would also respond to any requests that may be made

which would vary. The role also included overseeing any planned UOF and responding to any spontaneous incidents of UOF, engaging and listening to any requests from residents, attending and briefing the morning SMT meeting and being the initial point of contact in response to any matter. The Duty Director would be on call overnight and contactable by phone.

33) I have been referred to document **CJS004211** which is a weekly bulletin from the week commencing 14 August 2017. The document records that myself and other members of the SMT were to be Duty Directors during the day in Brook House, and then we were also on call at night. This was the usual practice back then, the reasoning being continuity. It made sense that if you were the Duty Director during the day, then you should also be Duty Director on call that night too because you would have a greater understanding of what had happened during the day (if anything) to then assist on the night on call if something else happened that was related to earlier incidents. This is not normal practice now.

34) The Inquiry have provided me with document **CJS004187,** the weekly bulletin for the week commencing 21 August 2017, and **INQ000057,** a signed Rule 9 witness statement from Michelle Smith. I have been asked to provide comment on an attempted escape by three detained persons while I was acting as Duty Director. I recall that there was an attempted escape, however, I could not provide comment on the specific details surrounding this incident as it was a long time ago and I cannot remember.

35) I have been referred to document **CJS004158** and page 34 of **TRN0000087** by the Inquiry. **CJS004158** is a weekly bulletin showing who was on duty the week commencing 22 May 2017 and **TRN0000087** looks like transcript of Steve Dix discussing plans to move a detainee. In relation to **CJS004158**, I acted as the Duty Director on call on 27 May 2017 and Sarah Newland acted as the Duty Director on call on 28 May 2017. This was standard practice. It was not uncommon to have a different Duty Director for each day of the week. In relation to **TRN0000087**, I cannot provide any comment on the removal being discussed because I do not recall this incident.

Organisational Structure

36) I have reviewed document **CJS000495** within which there is a note recording a discussion during an SMT meeting in March 2016 regarding a new proposed organisational structure in Gatwick IRC. I can see from this document that I gave an update on a restructure, but as this was so long ago I cannot remember any details about this proposed structure, who was involved in setting it up, or if/when it was set up.

Culture

37) Brook House had a mixture of challenges during the Relevant Period, such as a change in the drug sub-culture which covered the challenging use of NPS (also known as spice), this was not unique to us but across all custodial types of sites, and the community. In addition there was a high population of Time Served Foreign National Offenders (**'TSFNOS'**), long term placement of detainees and staffing challenges. All of this will have impacted on its culture.

38) In comparison to previous roles I have held, there are a couple of things that I noticed about Brook House. There was seemingly a long established grievance culture, and by this I mean that there seemed to be a culture of unhappy people who raised grievances as standard. In my 30 years working in other areas I had never really seen or dealt with so many grievances, and none were ever raised against myself. Here, I have had a couple against me which I have detailed below. There were many circumstances where I thought that a manager could have stepped in and dealt with the issue between the staff members without the need for there to be a formal grievance raised. Many of the grievances did not have any backing and were not necessary, in my opinion. I have been asked about document **CJS000463,** minutes of an SMT meeting that took place on 3 March 2016, which says under point 3 "*the amnesty from grievance is to end*". I do not know what this statement is referring to and therefore can provide no further comment on it.

39) On occasions within the IRC, you will have a large group of new recruits all joining and working through the induction process at the same time. I have always found that where groups start at the same time, there is a greater sense of team work and camaraderie between the group members. I imagine that this is because these individuals have all been together since day one and create a bond. As such, there is a better morale and culture between them compared to individuals who started on their own sporadically.

40) I wouldn't say that the morale of staff was excellent during the Relevant Period, however, you have to take into consideration the context of how the centre was. Working in an IRC is a very challenging job, it can be a stressful and strenuous environment where no two days are the same. It was also evident when staff members did not want to work here. I believe that these aspects would naturally lower staff morale.

41) In and around the Relevant Period there were also difficulties within the custodial estate as a whole with the use of NPS. This was not just an IRC problem, prisons went through this pain too. At the time, lots of residents had also been at Brook House for a very long time, this alongside the drug factor makes for a very challenging and difficult environment. This is no different to the challenges faced in other immigration centres or even prisons in terms of drug use at that time.

42) In or around the Relevant Period, I think I remember that one day we had 24 medical first responses. All 24 of these responses were related to NPS use. This was not because of security lapse, it (i.e. drugs) was just something that took hold of both this immigration centre, every prison in the country and the community at the time. We worked tirelessly to try and stem the ingress of these drugs into the centre. You also need to consider the length of time people are here. I believe that residents who have been detained for a long period of time within an IRC, with no known release or deportation date, are more inclined to use drugs. This is a key difference between an immigration centre and a prison. A prisoner goes into prison and gets 10 years. They will aim for five years with good behaviour and this provides something for them to aim for. In an immigration centre they do not have this incentive. You put a person in

detention and they have no idea if they are going to be here for a week or for a year. You have to put all of this into the mix to understand why it is such a challenging environment.

43) In addition to the above, with reference to staff morale, at one point, we had staff from Tinsley working here because Tinsley was shut for refurbishment. During this time, the staffing levels at Brook House was very high as you essentially had two centres worth of staff working at one centre. As soon as the refurbishment works were completed, the additional staff transferred back to Tinsley and the staffing levels at Brook House went back to 'normal'. This reduction in staffing levels would have been very noticeable to staff members who joined Brook House during the period within which Tinsley staff were also working here, as to them, the increased staffing level would have been the norm. They would not have known any different. The work load for each member of staff would have increased once the Tinsley staff left as there would have been less staff members to share responsibilities between. This may have led staff to believe that we were understaffed, which may in turn have also affected morale. I believe that this would have been around the same period as the Independent Monitoring Board (**'IMB'**) meeting minutes contained within document **IMB000048.**

In my opinion, from what I saw, staff always showed a professional and caring attitude towards residents in the environment within which we worked. I do understand that the detention environment can sometimes be very challenging. For example, you may encounter residents who are purposely being disruptive for one reason or another. This may be a resident taking their frustration with their detention status out on staff members. But in so far as I am aware, staff always took a professional approach. Although, I do appreciate that staff members would act differently in front of me as Deputy Director. Their persona with colleagues and attitude towards residents may have changed if I was present. However, having said that, I have never been made aware of staff members acting unprofessionally.

44) I believe that the values of G4S were integrity and respect, safety and security excellence, innovation and teamwork. I had no concerns around the values of G4S. I

believe that they only impacted positively on the lives of residents. We are there to provide a service and look after people and this was made clear within G4S. These values resonated with my own values as well. The values put out to us were about how we treat people and making sure we treat people well and decently. I would not have tolerated poor behaviour by anyone. I think as a manager it is important to understand how these values cascade down.

45) My own view is that this is also about how you deal with people. From my own personal perspective I feel I always did this well. I would expect to be told if anyone believed a staff member was not adhering to the values or treating others with care.

46) In my opinion, the interests of the management team were principally the day-to-day operation of the centre, the Home Office and any third party organisations. Management also had to consider the political side of their roles regarding such things as finances on behalf of the Home Office.

47) Balancing those priorities can be difficult but a lot of it was day to day challenges. We often had to be reactive rather than planning ahead. You will get questions from the customer coupled with challenges arising within the centre itself during the day in the centre. This is not something I have been used to in other environments.

48) I cannot recall any specific occasions from memory due to the time that has passed since the Relevant Period, however, in my role as Deputy Director, I would have been privy to some of the concerns raised by staff, whether this was through the formal whistleblowing policy or the general complaints process. If I was made aware of any occasion where someone raised concerns in relation to the treatment of a detained person, either formally or informally, I would evaluate the information, and make any appropriate decisions to seek further information. Consideration would be given as to whether a formal investigation needed to take place. If these were raised formally, normally through the complaints process, it would have been investigated and a written reply given or passed onto the Home Office by Karen Goulder for them, through their Professional Standards Unit (**'PSU'**), to consider whether to investigate.

49) I would expect staff to work in a professional manner, as a team and support each other at all times. In addition to this, I would also expect staff to report anything untoward in their dealings in day-to-day service through the processes and lines of communication available to them and hold each other to account.

50) The response of staff members when action is taken against their colleagues is not something I could really comment upon because I would not really be party to what they say. Procedures are in place for people to say something if they thought/think something was/is inappropriate. I think that people felt comfortable reporting or using these reporting systems as we did get a few reports from staff about staff as far as I can remember. If people do not have confidence in the system then they will not report any concerns, but this was not the case here. Here there were reports being made about various topics and so it is my belief and my understanding that these processes and procedures were being used by staff.

51) I understand that the 2016 IMB Report is noted as having high expectations of staff. I believe this clearly means that there is an expectation that people will carry out their roles in a professional, decent and competent manner. Staff have to have the best intentions, if you do not have this, something is seriously wrong.

Oversight, Monitoring and Outside Involvement

52) I have been referred to document **VER000116** by the Inquiry which is a service improvement plan from 2016 arising from an unannounced inspection of Brook House carried out by Her Majesty's Chief Inspector of Prisons (**'HMIP'**). This action plan was specific and was agreed by G4S and the Home Office. The SMT, including myself, would have been involved in drafting this plan as far as I can recall. The Inquiry has drawn my attention to particular recommendations and asked for my comment. Due to the significant time period that has passed since this document was produced, on review of the document, there are occasions when I can only provide comment on what the document itself says.

53) I will firstly discuss the recommendations that were accepted. I believe that the Home Office would review the recommendations that had been accepted and carry out checks to see if they had been done/implemented.

5.11 – This recommendation stated that the ACDT process should be reserved for detainees assessed as at risk of self-harm and should not be used to monitor those who do not eat food provided by the centre. I believe this was implemented and effective in creating change. My recollection of the centre prior to this recommendation was that there was no food and fluid refusal policy. Because of this, there was a tendency to put any individual refusing food and fluid (due to things such as protests) on an ACDT so that they could be monitored. I do not believe that this would have been the most effective use of an ACDT. Lots of food and fluid refusals are out of protest and it is clear that there is no intent from the detainee to seriously harm or kill themselves. Lots of protests have taken place in the past against the Home Office or against the detention itself. The Home Office realised that they needed a policy which could be used for individuals refusing food or fluid in cases other than where there was a significant risk to the detainee themselves or an intent to harm themselves. The food and fluid refusal policy therefore covers individuals whose refusal is for the purpose of a protest either against the Home Office or detention itself, rather than self-harm. If the reason for food or fluid refusal is one of self-harm, other processes such as ADCT are in place. In all previous cases of food or fluid refusal at Brook House, the resident involved has verbally informed us of the purpose for their refusal, and therefore whether it was a protest against their detention status, the Home Office or a self-harm attempt. If this information was not voluntarily provided by a resident, we are able to assess at the resident's record to see if their history could be used to determine the reason for their refusal. If there was ever any uncertainty as to the reason behind a resident's refusal, I believe that we would opt to put the individual on ACDT for their welfare and wellbeing.

- *5.13* – This recommendation stated that all staff should have effective training in the Adults at Risk guidance and that there should be effective multidisciplinary oversight of detainees in this group. I believe this was implemented and also believe it was effective in creating change. There are three levels of Adults at Risk and the purpose of putting this recommendation in place was to enable consideration of whether, if, for example, someone was a Level 3, should they be in the detention centre. I cannot confirm exactly what was done in relation to this but I do know it was a new policy and it is part of our daily work here now. Any new detainee arriving at the centre who is categorised as an Adult at Risk at Level 2 or 3 will be discussed in weekly meetings. These are multidisciplinary mutterings that are attended by representatives of the Home Office, healthcare team, substance misuse team, chaplaincy team amongst others depending on the circumstances surrounding the resident in question. The meetings were always chaired by a member of the SMT.

- *5.14* – This recommendation stated that there should be a multi-agency case review of detainees found by social services to be children. Brook House does not house children or women, however, we often get residents who arrive at the centre and claim to be under the age of 18. This policy is in place to protect those individuals. I believe it was implemented and I do believe it was effective in creating change in these situations.

- *5.18* – This recommendation stated that all Use of Force should be necessary, proportionate and competently applied. I can only go from the document itself when providing comment here. If the contents of the document are correct, I agree that it would have been implemented, but I would hope this was already being done and so whether it was effective in creating change I do not know.

- *5.19* – This recommendation stated that all detainees should have a private reception interview and experience robust first night and induction procedures. These recommendations were implemented. Although due to the layout of Brook House, we were only able to dedicate one room as a place where private interviews

could take place should staff or residents feel one is required. Regardless of where an individual came from (i.e. whether they were a Time Served Foreign National (**'TSFNO'**) or a non-TSFNO), they should still receive the same induction. I could not comment on whether it was effective in creating change because I would not be around these individuals as frequently as other members of staff.

- *5.20* – This recommendation stated that the management of perpetrators of violence and bullying should include monitoring and challenge of poor behaviour. There was an anti-bullying policy. I can't remember exactly what was in place at the time, but we certainly have an anti-bullying policy which is reviewed every year.

- *5.21* – This recommendation stated that the constant supervision rooms should be refurbished and cleaned. I recall that this was implemented. Murals were painted onto the walls and new flooring was laid to create a softer environment. Resident bedding was also changed to a softer colour tone. There is only so much you can do in terms of this and I would not be able to say if it had the desired effect but what I can say is it did brighten the room up. I am not a resident so I cannot say exactly what impact it had amongst detainees, but in my personal view, these improvements did create a softer and calmer environment.

- *5.22* – This recommendation stated all security procedures should be proportionate to a detainee population and based on individual risk assessments. This recommendation was partly accepted. On review of the document, I remember that this recommendation centred on the fact that detainees were locked up at night. It appears that this is what was being criticised from my reading of the document. Our response to this would have been that our contract was to operate the centre between certain times and so when we were not operating the centre we had to lock the residents in their rooms. G4S was contracted to operate its core day between 8:00am until 9:00pm. It would have not been possible to fully accept this recommendation unless the Home Office wanted the centre to be left open all night. We were doing what we were contracted to do. On this note, since Serco took over,

the times in which the centre is operated has expanded and the core day is now 7:00am until 10:00pm.

5.25 – this recommendation stated that detainees in the separation unit should be held in clean and fully furnished rooms. I believe that the centre is kept in good condition, and so yes this was implemented. For example, we repainted the walls of residents' rooms with a more durable and washable paint which was more suited for cleaning.

5.27 – This recommendation stated that each detainee should be asked about their welfare by their allocated care officer at least once a month. This was implemented and I imagine it would have created effective change for the residents. Each resident is allocated a member of staff on the wing who is their care officer. Residents should meet with their care officer at least once a month for a meaningful conversation. There should be records that this has taken place. This is still in place now and the wing Detention Custody Manager (**'DCM'**) is responsible for checking that records of these meetings are completed and filled out correctly. I cannot recall how often these checks took place. I think that they may have been completed either biweekly or monthly. If a DCM ever detected an issue during a check, I would expect the DCM to take appropriate action to resolve the issue identified. I myself as Deputy Director would not have been involved with this action so I am unable to comment any further on this.

- *5.35* – This recommendation stated that a drug and alcohol strategy should be established. I believe this was implemented and was effective in creating some change. I cannot recall if there was a drug and alcohol structure in place before these recommendations, I think there may have been.

- *5.44* – This recommendation stated all detainees should be able to access the welfare services when required and that interviews should be confidential and not interrupted by other detainees. This was implemented and I recall that the welfare office was moved to a different location. Prior to these recommendations, the office was in the main part of the centre so that residents could just walk in and out unannounced and whenever they wanted to. The office was moved to a different location behind a door which, in mine and many others' opinion, actually caused more problems. This was because residents would become frustrated when the door

was locked and they were no longer able to access the welfare services whenever they wanted to, as had been the case previously. I believe that the door was only locked when the office was left unattended. For example, if all welfare staff were working in other areas of the centre. Following formal discussions, a mutual decision was made by the SMT to move the welfare office back to its original location in the main corridor.

54) I will now discuss the recommendations which were rejected.

- *5.12* – This recommendation stated that a care suite for detainees at risk of harm should be established. I agree that this should have been rejected on the basis that I believe that we already have measures in place to assist these vulnerable residents, such as ACDTs and the use of E Wing if required. I also agree that the building design of Brook House would not allow for a care suite to be established. Room 10 at Tinsley House is a care suite. We have the option to move people there should we choose to use it but I cannot recall an occasion on which it has been used. This decision would have been aided by a security risk assessment.

  A care suite is created where the wall between two resident rooms is knocked down, creating two open rooms. An observation window is then placed in-between the rooms to create a physical barrier. One side of the room is furnished like any other resident bedroom with standard furniture. The other side of the room is turned into a viewing room with a sofa and chairs. Detainees at risk of harm would be submitted to the care suite and staff members use the observation room to provide a 24/7 watch service on the resident. This way, if the detainee requires intervention or care at any point, a member of staff is on hand to step in, take action and assist immediately.

- *5.23* – This recommendation stated detainees should not be locked in rooms and should be allowed free movement around the centre until later in the evening. This is effectively the same as 5.22 above. My comments remain the same.

- *5.24* – This recommendation stated that the rewards scheme should not be punitive or based on sanctions. I cannot provide any comment on this beyond what the document itself says. I do agree that it should have been rejected for the reasons stated in the document.

55) I have been told by the Inquiry that, at the same time as the above inspection, HMIP carried out a survey of detained persons, some of whom reported that they had experienced victimisation by staff members. I cannot recall if I ever received a particular complaint in relation to this from an individual. If a complaint was received, it would firstly go through the Home Office. If the complaint against staff was not sent to the PSU by the Home Office, then it would have been for us to investigate internally. As Deputy Director I did not have sight of all of the complaints that we would have though, only those which were upheld. However, as part of the SMT, we would go through the complaints tracker. These were sent out weekly. The tracker would contain all complaints. You would have a brief description of what the complaint was, who was investigating it and when it needed to be responded to. These included PSU complaints.

56) I have been asked by the Inquiry to set out my understanding of a number of bodies.

Independent Monitoring Board

57) I am aware of the IMB and, if they were on site, I would see them on a daily basis. I understand that they have statutory rights set out by the Secretary of State and these rights set out their role. We, as a centre or as G4S had no input into what they did. The role of the IMB is to monitor everything within the centre. They also have the right to look at anything they want. My understanding is that their primary function is to check the welfare of detainees and to make sure the centre is being run correctly. They would provide an annual report and I would have attended meetings every month to give an overview of the centre and discuss any matters of concern.

58) I believe that I had a good professional relationship with the IMB. If they were not on site, I would see them in any event once a month at the IMB monthly meetings.

59) Recommendations were often made by the IMB within their reports. If they had any concerns they would also raise these within the monthly meetings I attended. Following the annual IMB report, there would have been an action plan drawn up by Brook House based on the recommendations made. As far as I am aware, these plans would have been implemented.

Gatwick Detainees Welfare Group

60) The Gatwick Detainees Welfare Group (**'GDWG'**) was a body originally set up as an organisation to provide social and pastoral support for residents. They used to come and visit residents, especially those with no family, and provide maybe clothing and, on some occasions, they may give residents a bit of financial support if that person was destitute and had nothing. The service of the GDWG is invaluable in my opinion.

61) My interaction with the GDWG, as far as I can recall, was limited. They may come directly to me to discuss anything that they wanted to do. This would normally be initiated by the chair of the GDWG emailing me directly. I also held bi-monthly or quarterly meetings with the chair of GDWG, depending on any concerns raised. These meeting were always attended by the Home Office.

62) On the whole, it is my belief that my relationship with the GDWG was professional and positive. I helped them with their lottery funding portfolio and made arrangements so that they could come in to do some surgeries. I also recall working with members of the GDWG to improve support for children visiting the centre. This included stocking colouring books, colouring pencils and puzzles to kit out a designated children's corner in the visits hall.

63) I have been referred to documents **VER000249,** Kate Lampard's interview with members of the GDWG, and **IMB000003,** meeting minutes of the IMB Brook House meeting on 16 August 2017.

64) Within document **IMB000003,** myself and Paul Gasson (**'Paul'**) from the Home Office are recorded as having explained our reservations about some less appropriate actions by a couple of volunteers from the GDWG. There were certain members of the GDWG who became too involved in residents' cases. A lot of people thought this was inappropriate and thought that these types of actions would get in the way of what the GDWG was there to do. For example, they were getting involved with case work and questioning medical treatment given to residents. The IMB also raised concerns that members of the GDWG were contacting them to get information for residents. The IMB is meant to be an independent monitoring board, and so we had to have conversations with the GDWG about this. In addition, the group were raising safeguarding issues and healthcare complaints on behalf of a resident. However, they were not following the specific processes we have in place for raising concerns which created risks. Instead, members of the GDWG were contacting department representatives directly with concerns. Like the IMB for example. There was a risk that because the correct processes were not being followed to raise concerns, the information would not being recorded or cascaded down to appropriate persons to action as it should have been. This therefore risked a position where we may have missed vital information or not taken appropriate action were necessary.

65) It seemed like the GDWG wanted to come in to Brook House and to establish services that were beyond their scope. The services they were looking to enhance or implement were already in place and operated in accordance with the Gatwick contract. As such, either I or the GDWD had the power to make any changes to these services.

66) I have reviewed the statement of Anna Pincus of the GDWG, contained within document **DPG000002.** I have been asked by the Inquiry to provide comment on paragraphs 38, 155; 166, 173-174 of this document. An overview of my comments would be that it is not for Ms Pincus to diagnose a resident. The role of Ms Pincus, or any other GDWG member, in these circumstances would be to simply raise it through the appropriate channels so that it can be dealt with by the most appropriate team. This can be done though myself or the healthcare team. Every concern similar to this that I

received from the GDWG I would always go through healthcare to gain more information about it as they were the professional health services.

67) I have also been asked to review the oral evidence provided by Anna Pincus and James Wilson (**'James'**), GDWG Director, on days 13 and 14 of the Brook House Inquiry hearing late last year. My comments in respect of pages 48 to 50 of the day 13 transcript would be that these are Ms Pincus' opinions and views. I cannot alter that, however, I do very much disagree with what she has said. In response to the day 14 transcript, my comments are as follows:

- Pages 36 -60: I sought advice from the Home Office and was told to allow it. While I cannot recall 'refusing' any second interviews, I am concerned about James' comments regarding wanting to see clients for a second time with the purpose of exploring mental health issues because this was not the role of the GDWG. In this circumstance, I would have expected a referral to the centre via the prescribed processes to the Healthcare team. The purpose of these meetings was for GDWG to allocate a suitable visitor for a resident and signpost any further social support, clothing, money etc.

- Pages 74-80: I was aware of certain issues. My responses were either run past the Home Office and Ben Saunders, or chosen in light of my previous experience in order to protect the welfare of residents. At no point was I trying to be disruptive. I think that the GDWG are a great organisation and are valued in the IRC, but on some occasions they did cause me concern when they stepped outside of their role. The mental health of residents within our detention centre was our responsibility and it was managed appropriately within the centre in accordance with our policies. If an untrained person attempts to deal with someone with mental health issues they can make the issue worse. I was not aware of the criticisms raised by GDWG previously. This is all news to me. There was also a vetting process. It was not just me being a maverick saying no to them, the Home Office and Ben were also involved. The welfare of residents was at all times at the forefront of my mind.

- Page 88: I am comfortable with the GDWG carrying out tasks that fall under the remit of their role with assisting the centre and where they do not go against the processes we have in place.. That is what they are there for. If they don't operate within the policies and processes in place, it becomes dangerous. I was not being defensive or dismissive, I was just trying to maintain the protocols in place to protect our residents. We were just mindful that the way in which the GDWG were operating could sometimes create a risk and we don't want to risk anything.

- Pages 103-104: it is legitimate for the GDWG to raise concerns. We do not audit the GDWG. I cannot recall this conversation.

68) Overall, I believe I had a good working relationship with the GDWG, and, although there were issues about their roles and discussions were had, we were supportive of them.

69) I believe that I, G4S and the Home Office treated GDWG fairly during and prior to the Relevant Period. It was appropriate for me to raise concerns to them that had been raised to me. Whether they accepted them is another issue. We tried to assist them with accommodation during COVID-19 and gave them the visit hall to conduct their 'drop-in sessions' when they couldn't use their original rooms because they were too small. We never stopped them from visiting residents, but we had to be COVID-19 secure, so we had to change rooms. Any perceived resistance from me is entirely misconceived.

Medical Justice

70) I am aware of Medical Justice but they would communicate directly with healthcare and so I would have no interaction with them as far as I can recall.

Bail for Immigration Detainees

71) With regard to Bail for Immigration Detainees, I recall that they were around and at one point we had a representative on site. We still have access to them but the funding for someone to be on site is no longer around.

Other External Bodies

72) I would have had involvement with other external bodies such as the Police, law enforcement agencies, and different parts of the Home Office. I believe I have a good understanding of what each of these bodies does and their role in relation to an IRC. It is not uncommon to get a phone call out of the blue and be asked to deal with things by these different bodies. These bodies could include those listed below.

West Sussex Social Services

73) I did not really have a relationship with West Sussex Social Services. They would deal with Head of Services based at Tinsley House. The Pre Departure Accommodation Managers would have a good relationship with the Council.

74) I have been referred to paragraph 159 of Dick Weber's interview with Kate Lampard at document **VER000229.** I believe the processes are quite clear for anyone who claims to be underage. If the Home Office cannot confirm that an individual who claims to be underage is in fact over the age of 18, then we will report this and see whether social services have any differing information. While this process takes place, the individual claiming to be under 18 will be moved to Tinsley House as the male environment is softer there. Sometimes the individuals might be moved to E wing in Brook House as it is smaller.

75) We cannot disagree with someone claiming that they are underage. It is up to the Home Office to determine whether someone is under or over 18 years of age. If the Home Office cannot confirm this information, this would be reported to Social Services to investigate further.

76) I cannot recall the specific incident Mr Weber is discussing at paragraph 159 of document **VER000229**, as such I would be unable to provide further comment.

77) **IMB000030** contains the minutes of an IMB meeting on 17 May 2017. I cannot recall specific details of the events referred to at Item 5 of these meeting minutes relating to D852. If a minor arrived at Brook House it is usually the case that the resident arrives and declares that they are underage. Following a referral to the Home Office, I can see that, on this occasion, a referral was also made to West Sussex Social Services to investigate the matter. As I cannot recall this incident I would not be able to provide any comments on my immediate reactions or the steps taken thereafter.

Police

78) I feel that I had a good relationship with the Police before and after the Panorama broadcast. We had staff from the Police station working in the centre as Police Investigating Officers who would assist us with any contingency work. Incidents involving discipline, height, hostage, suspect parcel, or escape would normally be reported to the Police. In terms of the reporting process, for example if there was an assault, this would be reported to the Police by the security department via a call to the Police station.

79) The Memorandum of Understanding (**'MoU'**) between G4S and West Sussex Police sets out that the Police would assist if there was a serious incident at Brook House. This MoU was between us, the Home Office and the Police. I note that this has been referred to by Paul within document **VER000256.** Staff would not necessarily know about the MoU because it was for the Managers.

Forward Trust

80) Document **VER000222** is the Kate Lampard Interview of Anton Bole (**'Anton'**) from the Forward Trust. I feel that I had a very positive relationship with Anton. He was very knowledgeable. The role of the Forward Trust was to support residents with drug

problems. They would provide short term programmes to assist them. There was an understanding from the commissioners meeting that the Forward Trust would have a line of contact with healthcare and the initial agreements were that healthcare would provide the IT. However, no one took responsibility for this and I ended up having to support this. Anton wanted to move to the chaplaincy office. We could not move them there at this time because there were already 9/10 employees using the office. There were only three members of Anton's team. We offered him another office and they are now located in an office outside the induction wing where residents can gain easy access to them and the services they provide. I cannot recall if Anton requested this within the Relevant Period, initially he asked for the chaplaincy office but it would have meant moving 9 members of the chaplaincy team. But we agreed an office on the main activity corridor next to the induction wing Beck Wing. I cannot recall exactly when this relocation took place, but I believe it may have been after the Relevant Period.

Physical Layout of Brook House

81) The building was designed and built on the specification, I would assume, set out by the Home Office. It is my understanding that Brook House was designed as a short tem holding centre and so the initial purpose of the building was to take people in and very quickly move them on for flights rather than housing people for long periods of time. As discussed in my interview with Kate Lampard [**VER000248**, paragraph 192], the building is what it is; it is designed and built to what I would consider a similar specification to a prison and there are no changes I could make to it, only manage the contract within the confines of the building. I believe we made best use of the areas that were made available for residents.

82) In my opinion, Brook House IRC was built to a Category B security standard. Every Category B prison is different so it is hard to give a standard picture of what a Category B regime looks like. Nevertheless, the general definition for a Category B prison is a closed prison for those who do not require maximum security but for whom escape still needs to be made very difficult.

83) I do not think that it is my place to say whether Brook House is fit for purpose in terms of being an immigration removal centre, this would be for the Home Office to take a view on. But I do think Brook House is restricted to the confines of the building. It would always be nice to have more open space or a bigger gym, greater activity areas and more recreational areas, but this is not possible in terms of the space available. It would not be a realistic suggestion to make these changes. Yes you could try and build a two story building on one of the four courtyards and have the bottom floor as a gym and the top as classrooms or recreational space, but the trouble is finding someone who is going to fund that.

Additional Beds

84) In or around 2017, I remember additional beds were introduced at Brook House. This would clearly have an impact on space available for detained persons. Extra staffing and some scope for greater activity was built into the contract for these beds. At the time, the Home Office was reviewing the capacity levels across all IRCs and were implementing changes to maximise space.

85) The beds were a controversial addition but with the beds came extra funding and staffing to manage additional capacity. Brook House is culturally diverse. Certain cultures enjoyed more people being together as they were close knit communities, however, other groups of residents hated it. However, this was a Home Office initiative that G4S were required to abide by. I remember Andrew Mitchell was all for the additional beds, however, at some point Steven Shaw was asked to do an independent review. I am not sure who asked him to do the report. I do not believe that it was an internal G4S investigation because it is a public report as far as I am aware, so it may have been the Home Office. I'm not sure what triggered the report either.

86) Steven Shaw's review recommended that the additional beds be taken out. I cannot recall exactly how long the additional beds were in Brook House but it wasn't for long at all. A scope of works was then formulated to remove the additional beds.

87) I have reviewed document **CJS000582** which contains the minutes of an SMT meeting on 13 of April 2017. Within this document Juls Williams is noted to have said *"[U]nsettled across the wings. A few assaults and boisterous behaviour. There has been no impact with additions beds. Some detainees do not want to share but others are happy to have three detainees in a room*." I recall this being a salient entry of a longer conversation, however, I agree with the statement.

88) I have been provided with documents **VER000225**, the transcript of Michelle Brown's (**'Michelle'**) interview with Kate Lampard**, CJS000583,** minutes of an SMT meeting on 25 October 2016, and **VER000230,** the transcript of Iman Zeeshan Qayyum's (**'Iman'**) interview with Kate Lampard, by the Inquiry. The rooms in Brook House which accommodate detainees are larger than cells in the prison services. Tinsley House also has up to eight bunks in one room. Personally, I do not support the idea of anyone in an IRC or a prison environment sharing a room.

89) When the bunk beds were brought into Brook House, additional control and restraint training was required. We sought advice from national training teams on how to deal with it. There is no set guidance or practice for moving people off the top bunk of a bunk bed. The bunkbeds did pose additional risks that needed to be assessed and we therefore tried to train for Use of Force intervention with a bunk bed involved and sought advice from the National Tactical Response Group accordingly. This training was provided by the C&R trainers within the centre. This consisted of practical advice.

90) I have been asked to provide comment on document **IMB000003,** specifically Item 5 at entries 'week commencing 24 of July' and 'week commencing 31 of July' 2017. These entries appear to relate to a detained person with reduced mobility. I do not recall this incident and so cannot comment whether or not it took place. From memory alone, I am unable to recall any similar incidents.

E Wing

91) I believe that E Wing was used to assist in charter removals before I arrived. Over time its purpose changed and it was used to accommodate residents who had mental health issues, those that may be vulnerable on the larger wings and sometimes those that displayed challenging behaviour. E Wing was/is a smaller, quieter, more discreet unit, which, due to its size, allows, staff to dedicate more time to the residents and provide greater support to them. Anyone who was moved from E Wing back onto a regular wing would have been reviewed by healthcare, a mental health nurse and a DCM and/or SMT member. There would have been management oversight before there was any removal from the wing onto a regular wing.

Policies and Procedures

92) The Inquiry have provided me with a number of documents, advising me that the documents contain policies that were in force during the Relevant Period. I have been asked to confirm my awareness of the policy and whether the policies were used. I will take each one of these in turn.

- Document **CJS000710:** Home Office Detention Services Order 12/2012 on Room Sharing Risk Assessment issued in September 2016. I know of this policy and recall that it was brought to my attention at some point post September 2016 but could not confirm when. I know it was also available on the intranet and I believe the policy was used by staff.

- Document **CJS000711:** G4S Gatwick IRC's Incentive Scheme Policy dated 5 August 2014. I have heard of this policy and believe it was around in the earlier part of my employment, however, I do not believe this policy was in force in 2017 during the Relevant Period.

- Document **CJS000717**: G4S Detainee Reception and Departures Policy dated 4 May 2016. I knew of, and I am aware of, this policy and I believe it was being used by staff. I would often use this policy as a reference document.

- Document **CJS000718**: G4S Gatwick IRC's General Security Risks Policy. I am aware of this document and satisfied that it was being used by staff.

- Document **HOM002511**: Assessment in Care and Detention Teamwork. I am aware that we have an ACDT policy in place and we also had one during the Relevant Period, however, I do not recognise it being in the format as shown in **HOM002511**. I know that this document says it was due for review in 2008 so this might be a very outdated version of the policy. Staff followed the ACDT processes routinely.

- Document **CJS000507**: Supported Living Plan. I am aware of this document and satisfied that it was/is used by staff.

- Document **CJS006224**: Minimising and Managing Physical Restraint (**'MMPR'**). I am aware of this policy, however, it would not have been used at Brook House because this document discusses the use of Control and Restraint for younger people. MMPR was a technique brought in for the juvenile estate. This does not apply to Brook House.

- Document **CJ0000721**: Violence Reduction Strategy. I am aware of this document and satisfied that it was/is used by staff.

- Document **CJS000725**: Removal from Association (rule 40) Care and Separation Unit Policy (22 August 2016). I am aware of this document and satisfied that it was/is used by staff.

- Document **CJS000726**: Age Dispute Policy (reviewed 13 April 2016). I am aware of this document and satisfied that it was/is used by staff when needed.

- Document **CJS000727**: Detention Services Order 03/2015 handling of complaints (Feb 2017 vs). I am aware of this document and satisfied that it was/is used by staff.

- Document **CJS000731**: Home Office Detention Services Order on Management of Adults at risk (Feb 2017). I am aware of this document and satisfied that it was/is used by staff.

- Document **CJS006083**: Gatwick IRC's Drug and Alcohol Strategy (2017/18). On review of the strategy, I recall that I created this document by adapting and amending an existing document that I had from my time in the prison service. I used this previous document as a template. . I was therefore fully aware of the policy. I know I was involved in putting the strategy together and implementing the same when I was Deputy Director.

- Document **CJS004359**: Regimes & Activities Policy Feb 2017. I am aware of this document, however, I would not be able to confirm whether I have read it or not. It is likely the document would have been available on the intranet.

- Document **CJS004362**: Removal from Association Policy (August 2016), this document is exactly the same document as **CJS000725**. My comments on this document are contained above.

- Document **CJS000676**: Detention Services Order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42). I am aware of this document and satisfied that it was/is used by staff.

- Document **CJS000724**: Home Office Detention Services Order on care and management of detainees refusing Food & Fluid. I am aware of this document and satisfied that it was/is used by staff.

93) I believe that the policies outlined above were very useful for staff. If a staff member is ever unsure of what to do in a situation, the policies are extremely clear as to what the policies and procedures are. I believe that they are easy for staff to follow and also easy

for staff to access. On occasions, staff members have asked me questions about different procedures and, rather than tell them verbally, I often refer them to the actual policy itself so that they can refresh their own understanding.

94) I believe that the policies are regularly maintained and updated and, for the most part, reviewed once a year. I know that we always have someone in the compliance team reminding us of policy review dates. As Deputy Director during the Relevant Period, it would have been part of my role to review the policies.

95) Unless stated otherwise within paragraph 92) and its subsections, I believe all of the policies discussed above were the policies we had in place, the policies we would abide by and that the policies were reflective of Brook House during the time.

Training

General Training

96) The Inquiry have referred me to document **CJS006085** which relates to the initial training course (**'ITC'**) undertaken by Detention Custody Officers (**'DCOs'**). I did not undertake this training because I was not recruited as a DCO. I came in at SMT level and have worked in the custodial industry for over 30 years.

97) Prior to working at Gatwick IRC I had, over many years, undergone all of the appropriate training. I had carried out a number of training courses that were appropriate to my grade. I had passed many types of assessments that gave me the skills and attributes required to carry out my role. However, on starting at Brook House, due to it being my first experience in an IRC rather than a prison, I did an induction period as such which allowed me to familiarise myself with my new surroundings, understand the sites and understand what was expected of me. My 'induction' probably went on for approximately two weeks and during this period I visited different areas of the centre, met with different people to understand their roles, read (and understood) any policies

and procedures that may have been relevant to me carrying out my role and did a bit of shadowing in different areas.

98) My experiences and previous roles have equipped me for the role I was carrying out at the time of starting employment at the IRC, my subsequent role of Deputy Director at Brook House, and my role now. I accept, however, that moving from the Ministry of Justice and working for HMPPS, and moving over to Home Office policies and procedures, would be a challenge and different, however, that would be an expectation of the role I was carrying out. I believe that the induction I received was sufficient in my circumstances. I would have said something at the time if I believed any induction or training to be inadequate.

99) I believe you can always look at training and say, 'well maybe we could do more of this', however, on reflection, for DCOs, the ITC is part of a national curriculum which provided them with a basic foundation for them to carry out their role. The ITC is followed by two weeks of shadowing. The shadowing period includes 'night shadowing'. From memory, night shadowing has always been part of the initial training since I started working at Brook House. DCOs would use the training they had been given, which was more technically based, to assist them in their role. In my opinion, by actually working within this environment you gain confidence and experience which cannot be taught. This means that training, in reality, continues beyond the ITC and the two week shadowing because you are always learning on the job.

100) I went to every ITC I could when I was Deputy Director and I would usually hold a talk providing an introduction about who I am, the challenging work environment and an overview of what their roles would involve. I would always meet all new staff who attended the ITC. I would usually do this during the first or second day. On occasion, during the training, I would catch up with new staff to keep myself appraised of the ongoing training.

101) In relation to DCMs, I would potentially be involved in the recruitment process. If successful in their application, after the DCM has been allocated a role it would be

down to functional leads to tailor their training needs and these would be discussion points on any one-to-ones with those managers.

102) I have been provided with document **CJS000575** by the Inquiry which contains minutes of an SMT meeting that took place on 3 May 2017. Within this document I can see that there is reference to the 'residential regime document' which was to provide core day information on the ITC. I cannot recall whether it was adapted and therefore cannot explain how it was adapted or the impact it would have had.

103) If I was to make any change to the ITC, I would swap the process around, so you would complete the two weeks of shadowing before the ITC starts. So then, when you go on the ITC and deal with its content, you have a better understanding of what it is as a result of the knowledge you have obtained from having completed the shadowing.

104) Upon consideration of document **CJS000582**, I can see that there were suggestions that new members of staff should have a mentor. I recall that there was a mentoring pack, but it looks like this was an action for Michelle Brown to complete. If this was the case, then I imagine it would have been implemented because Michelle was pretty efficient at getting action points done. I had no direct involvement in this.

105) All DCOs, as part of their contractual requirement, had to carry out yearly staff refreshers in Control and Restraint/Use of Force, with a set mandate. This is also the case for the SMT. I cannot recall any other training that would have been required at the time.

106) It is my understanding that a number of the activities team were regularly put on, a level 2 gym instructors course. These courses would give them the relevant qualifications to specifically carry out this role.

Managerial Training

107) Over my time as a Senior Manager in general, which is 20 years plus, I have carried out numerous managerial training courses that have been relevant to my role. In terms of any training specifically done whilst employed by G4S, I recall that I did some training around personal development, however, this was not done within the last five years.

108) Reflecting on my time as a manager at Brook House, I believe it may have been beneficial for me to receive more non-operational training to find out more about the business side of the organisation.

Use of Force

109) When I joined G4S I had already been trained, and refreshed, in Use of Force training over the 35 years prior. I therefore did not require further training on arrival. I continue to have yearly refreshers to stay in ticket. I can only recall three occasions in which I have had to use force while working at Brook House. One was when a detainee came running towards me as if they were about to hit me. On this occasion I pushed the detainee away. This is really the only type of incident that would require me to use force at Brook House, i.e. if I was about to be attacked. On another occasion, a resident tried to get out of his room whilst we were in a state of being locked up. On the third occasion, a resident tried to barge past me as I entered a wing and he want to get onto a wing he was not allowed on. All of these are considered to be minimal uses of force. I recall that I completed all relevant Use of Force paperwork following all of these incidents. This would have included a Supervisors Report, Annex A Officers Report and 213 Medical Examination Report.

110) Use of Force training was carried out by qualified instructors, certified by NOMS, to carry out all the Use of Force training and I always believed the training was of a good quality.

Development

111) I have been provided with document **CJS004275** by the Inquiry. Having considered this document it looks to be a contemporaneous note and I therefore have no reason to believe that it is not accurate.

112) In many custodial settings you identify a pool of DCOs that you feel have the potential to progress into the DCM role. I can see that within document **CJS004275** it is reported that I said "*Gone the right route with new DCMs and temporarily promoted DCOs to DCMs"*. I assume 'gone' should be 'going', but here I would have been saying that the DCMs that had been promoted were performing very positively. I can also see that document **CJS004275** records that "*DCMs consider themselves to be operators and are not developing talent*". Some DCMs consider themselves as an operator of that area and therefore not a mentor for other junior staff members. DCMs must do both aspects. It is important to develop staff and it would be an issue if there were not doing this because it would indicate that they are not managing their staff properly.

113) I have reviewed document **CJS000503.** After this meeting, the discussion I subsequently had with Jane Shannon arose from there being a general issue in the custodial environment that there was not a program in place for first line managers (i.e. DCMs) to be part of a scheme for development and assisting them in becoming a better manager. Jane Shannon was meant to be putting together a training programme for first line managers. This was discussed at the training reviews. The apprenticeship was centred on implementing a programme for first line managers.

114) I think a number of attempts had been made to roll out the G4S development programme, but I cannot recall it being fully rolled out prior to Serco taking over the Gatwick IRC contract.

The Role of a Senior Manager

115) On a daily basis, I would strive to walk around the centre, visiting all wings, all association areas and generally engage will all residents. It has always been in my nature to do this as I like to get around and meet people. I enjoy the interaction. I would also

engage with residents in a more formal way, for example, whilst carrying out reviews. If I felt it necessary, I would make use of an interpreter whether this was informally where another resident would interpret, or by a formal means of using a recognised interpretation company such as Language Line or Big Word. For any formal processes the interpretation company would be used.

116) I would have engaged with staff on a daily basis. When I was on duty I would attend all morning briefings, which occurred in the Visits Hall, prior to staff starting their duties. I would attend these meetings to listen to the briefings being given, to add any comments I wished to add and give staff regular updates on what was happening around the centre. As mentioned above, on a regular basis I would also walk around the centre and engage with staff in all areas.

117) During my time at Brook House, there has not been an Incentives and Earned Privileges (**'IEP'**) scheme. The only policy in place to deter poor behaviour was the use of Rule 40 (Removal from Association), which could be used to respond to poor behaviour of violent and refractory individuals. Had there been an IEP scheme, I believe, from experience, that this can, in some cases, encourage positive behaviour in some individuals.

118) There were a number of measures in place to prevent drugs from entering Brook House through our security strategies and visits procedures. It is a very a challenging area. It is difficult to stop drugs entering any secure site and, as a general rule, you cannot rule out staff corruption and the fact that, with visits as an example, it is not uncommon for people smuggling items into a centre to utilise body orifices. In IRCs you do not have the powers of search that you have in prisons, for example, you cannot search orifices. In my opinion, the aids we have here (and I imagine in other IRCs) for scanning for drugs is pretty minimal. We do not have body scanners and we have no use of dogs.

119) It is difficult to say whether the process was successful or not because drugs were still somehow entering Brook House despite our best efforts. People will try all sorts of methods to smuggle drugs into the custodial estate and methods of doing so are

constantly evolving, nowadays people are even soaking clothes in PS. I believe that, even by spending an extortionate amount of money to prevent drugs entering a centre, you can reduce the amounts coming in, but there will never be a way to stop it fully.

120) Any resident, or staff member, caught would have been reported to the Police and for residents local measures such as closed visits may have been used.

121) I cannot recall ever being concerned that financial, commercial or reputational pressures from G4S, if there were any, had any impact on my ability to perform my role to ensure the health, safety and wellbeing of individuals detained at Brook House.

122) I cannot recall any specific barriers that prevented me performing my role, but my experience of working in this role, and other similar senior management roles I have carried out, is that you work in a challenging environment having to meet the needs of residents and staff, the customer and all third-party organisations that work within this environment.

Security / Drugs

123) I have commented on this matter within the above sub heading of this statement, however, I note that the Inquiry has asked me a number of questions specifically relating to this topic. I will therefore answer these questions below.

124) The Inquiry has provided me with the SMT meeting minutes dated 28 February 2017 [document **CJS000492].** As this is a contemporaneous note of the meeting, I would assume that it is an accurate record of what I said.

125) My comment within this meeting with regards to the issues surrounding information security is a reference to me expressing my intention to bring the centre's management of data up to a higher standard. At that time, there was no obligation on G4S to operate in accordance with ISO270001. ISO270001 is the international standard for information security, and provides a framework to establish the best practices required by

regulations such as the GDPR. I recall that I encouraged all Department Heads in the centre to review the standard and look at ways in which they can implement its standard practices. I can confirm that this is the "*big piece of work*" that is referred to in document **CJS000492**.

126) The Ministry of Justice has a 'local security strategy' which was an IT system and it was set out as a framework. It involved different security modules. Each module provided processes and protocols that you would adopt to manage security. We would discuss this at the centre security meetings as a way going forward as well as locally. Unfortunately, this matter never materialised as the centre did not have the IT capability to support it.

127) I have also been directed to SMT meeting minutes dated 9 February 2017 at document **CJS000555**. Once again, as this is a contemporaneous note of the meeting, I would assume that it is an accurate record of what I said.

128) The references highlighted by the Inquiry within these minutes relate to a period within which we were experiencing a high level of drug issues. Around that time, we received intelligence from a number of SIRs that staff members were responsible for bringing in prohibited items, including drugs, to residents. As I may have previously mentioned, SIRs were confidential forms that allow staff to highlight any suspicions or concerns about other staff members, sometimes anonymously.

129) We would collate and log all information submitted by way of SIRs. Further investigations would be carried out off the back of information provided where warranted. We cannot act on every piece of intelligence we receive. We must wait to formally challenge members of staff about allegations until we have a substantiated, robust case with credible evidence.

130) I do recall that we also experienced some difficulties with staff in Visits around the same time. I cannot remember any specific measures that we put in place around this

time, but I imagine that I would have tried to get around the centre every day and reiterate the importance of being vigilant to staff.

131) The process of investigating SIRs raised by staff includes the role of a Security Collator and Security Analysts. The role of an Analyst is to analyse the information provided in the SIRs. It is their job to review the report and provide an assessment of information and recommendations of what further information is required going forward.

132) The specific role of a Collator is to collate, process and summarise all information contained on the individual(s), including in the SIR, by interviews conducted and by other means, into one report. This report is then provided to the Head of Security who will make a decision on the appropriate enforcement action to take (if any) against the individual(s) named in the report.

133) It is important that a Security Collator and Security Analysts are separated as they cannot be privy to the same information. Unfortunately, at that time, these roles were working in the same office so could not be separated in physical terms. I was therefore keen for this to happen and we are still working to implement a suitable solution.

134) I have reviewed document **VER000248**. I enhanced the intelligence system by introducing a new managerial role to oversee corruption prevention. I also secured further funding for this area which allowed staff members to have laptops and be provided with further training. We have also worked closely with the Police on corruption prevention.

135) I do believe that the improvements made to the intelligence system were effective. Some investigations under the new system identified that certain members of staff were involved in corrupt behaviour. This led to several dismissals. For example, a former employee, Leah Winston was dismissed for bringing unauthorised items into the centre.

136) I can confirm that I did possess intelligence with regard to members of staff bringing drugs in Brook House prior to the Panorama Broadcast. I cannot recall exactly, but I

would have received this information directly from the Head of Security and the nominated Head of Corruption officers. At that time, these were Kelly Harris, Carrie Dance-Jones (**'Caz'**), and Dan Robinson.

137) The Inquiry have asked me to confirm what is meant by the "*good work*" referred to at Item 4 of document **IMB000015**. This would have been a reference to staff being proactive with searches, observations and successfully tacking the interception of drugs coming into the centre via Visits.

138) Michelle was responsible for the introduction of the UK Border Agency drugs dogs at the centre, as referenced within document **CJS000915**. It was agreed that the dogs would come into our centres and perform drugs searches. This was seen as beneficial for both parties as it provided the dogs with experience in different areas of work and practice, and we benefited from their services. The drug sniffer dogs only attended a couple of times. I recall that there was a particular problem with lorry drops around that time. So the dogs were quickly deployed to the border to assist there.

139) I can confirm that searches were conducted against both members of staff and residents. Illegal drugs were detected during some of the searches undertaken but not in the possession of staff members.

140) I have reviewed document **SXP000159**, which is an investigation report dated 22 September 2017 in respect of D1467. I cannot remember any specific details surrounding this investigation and the meeting referred to in the document. I am also unable to recall the specific incident referred to at pages 24-25 of document **HOM0332003.** However, from the document provided it does appears that an investigation was conducted in line with the processes and procedures in place at that time.

141) I would have been made aware of the assault on D1467 on 29 December 2016 as an incident of this type would have been discussed during the morning meeting the next day. I cannot, however, remember the exact steps that were taken to deal with this

matter. As above, I cannot recall whether I was aware of D1467's complaints prior to receiving the letters dated 4 January 2016 and 14 September 2016.

142) I have considered document **CJS0073663** provided by the Inquiry and there is no sentence underlined in bold for me to comment on.

143) I have reviewed the allegations made against Luke Instone-Brewer and Babatunde Fagbo contained in documents **CJS0073682** and **CJS0073677**. I was not surprised by these allegations as we were already conducting discrete investigations into these two members of staff at that time. These staff had been on our radar following intelligence received through a confidential SIR.

144) As I have explained above, you cannot act on the first piece of limited evidence you receive. We had to build a bigger picture, obtain evidence and formulate a case against them. You only get one chance to challenge an individual, so we had to ensure that our case was robust before we took any action. I ensured to monitor this with my corruption team. I recall that we did inform the Police when these investigations came to light and they were also conducting an investigation.

145) With reference to the investigation carried out into Leah Winston in this regard, as documented at document **CJS0073492**, as above, this member of staff was already on our radar. I recall that one day, Leah randomly came to Brook House when she wasn't on shift. Whilst at the centre, she visited various residents in areas and wings that she had no prior business in. This instantly raised suspicions. When we looked back at the CCTV you could see her meeting up with residents to conduct passes. It was evident that the residents had agreed to meet her at an agreed collection point.

146) I was in charge of conducting the investigation into Leah. Once I had collated sufficient evidence to support our case, we were able to put our case forward to her. I recall that I held a formal interview with Leah as part of the investigation. I then compiled my investigation report. Ben chaired and heard the disciplinary hearing. After reviewing

the evidence put forward, Ben decided that the appropriate course of action for this case was dismissal.

147) In addition to those I have already mentioned, I cannot recall any other members of staff at Brook House who were investigated for supplying drugs.

148) I have reviewed document **VER000256**. Staff drug searches were undertaken spontaneously around once a month. I do not think that any drugs were detected during the last search conducted.

Managerial Oversight

149) I do not recall ever experiencing, nor was I ever aware of, any racist attitudes or behaviours, or any homophobic and/ or misogynistic attitudes or behaviours amongst staff during the Relevant Period, or at any time during my employment at Brook House until Panorama aired. If I had witnessed any such behaviours, I would have reported them straight away. When I watched Panorama, I was shocked at the behaviours displayed.

150) I never witnessed staff bringing drugs into Brook House, nor was I personally aware of the same. However, I do recall some staff members highlighting their suspicions about other staff members through the confidential Security Information Report (**'SIR'**) process. These SIRs would have been submitted, logged and investigated, but I cannot recall a specific case where there were any fines or convictions of any member of staff. If I had any concerns about a staff member bringing drugs into the centre I would report it without delay.

151) I do not recall ever experiencing bullying by any other staff member at Brook House. Furthermore, I do not recall having any concerns about other staff being bullied to my knowledge. As Deputy Director, I may have had to deal with staff complaint(s) regarding bullying during the Relevant Period, however, I cannot recall any specific cases.

152) As above, I tried to get around the centre every day and always met with staff if I came in early. I was probably the only member of the SMT to go and see the visit rooms. I feel like I was a visible member of staff, would listen to people and try to get around the centre most days. I feel like I am pretty good at picking up on things and if there was something not quite right I would hope I would notice this. When walking around the centre I would often be a point of focus for residents because they assumed I was a member from the Home Office. Most of the questions asked of me by residents are around casework.

Senior Management Team

153) There was always a morning meeting held at which a number of functional heads might attend. Each functional head would normally hold their own meeting once a month or so as well. In my personal opinion, in general, meetings are not always effective. Many of the meetings we have are mandatory. However, it is hard to say looking back whether the meetings were effective or not. I do believe that they were an effective way for functional heads to feed information back to their staffing groups. In hindsight, we could have probably achieved more from them. If I had any concerns about the content, format or effectiveness or the meetings at the time I probably would have made this known.

154) SMT meetings are held monthly and within these we discuss different matters that may have arisen within each function that month. An agenda will be sent out before the meetings and then we will go through that during the meeting itself. The agenda will usually cover things like departmental updates, audits and compliance matters, and operational updates/matters. We will look through functional heads' reports and directors' feedback.

155) Use of Force incidents will often be reviewed at SMT monthly meetings. If any Use of Force incidents are reviewed, depending on the nature of the findings, this could lead to advice being given to staff by a Use of Force instructor who would provide

professional feedback to those involved. If there had been concerns raised by staff or residents in relation to a Use of Force incident, whether this be the actual use of force in the first place, or conduct within a Use of Force incident, this could potentially lead to a formal investigation. This investigation could be a local investigation or a PSU investigation.

156) In my opinion, the quality of the leadership by Senior Managers at Brook House was probably not as good as it could have been. Individually there were some bright members of the SMT, however, particular members of staff were not team players. Because of this, looking at it as a team, I did not think it functioned as well as it could have done. Individuals acted as individuals and therefore did not work together as an SMT. I have worked with so many SMTs during my career and each one has had its strengths and weaknesses. I did find the SMT group different to other management groups I had worked with before. My personal opinion is that the challenges previously within the SMT before I joined still had an impact on how the SMT functioned during the Relevant Period. I make it clear that I am not saying they did not do the job, just that it was more of an individual mentality rather than a team mentality. Personalities in the team that may not have been close, but as individuals they performed their roles and personality may have been a contributory factor in why it seemed less of a team atmosphere.

157) I feel it was a case of having an SMT that has grown with the centre. This means that many of the SMT had probably never worked anywhere else or experienced anywhere else and therefore that is what they believed the workplace should be.

158) I do not see within the Home Office what I saw in a previous life working at the prisons; guidance and direction. When I worked in the prison service there was always guidance and yearly plans about how it operates. We are working on this at the IRC now by looking at positive detention culture. But still, you do not have that corporate vision from the Home Office in my opinion. The Home Office's aim in relation to Gatwick IRC is to move people out of the country and that is basically it. There is no vision

about progression over the next five or so years. Because of this, it is also likely that no one in the SMT would have vision and more likely that they would just follow the status quo without challenging it.

159) During the Relevant Period, Gatwick IRC was basically running on contract extensions. I believe this was to its detriment. I recall that the contract was on an extension when I joined in 2015, and then there were also two further extensions before Serco took the contract over in 2020. When you have such short extensions or short contract periods it is difficult to see how or why an organisation would invest money in something that it will only be in charge of for, say, two years or so.

Relationship with Senior Managers

160) During the Relevant Period, my direct line manager would have been the Director of the centre, Ben Saunders. My appraisals were conducted by Ben. My role as Deputy Director was to support Ben in his work. We had a good professional working relationship and we worked closely together. Ben was a nice bloke, however, I feel that when you lead an SMT it is about presence and making sure you take control of situations because it can be a difficult and challenging environment. This was not really Ben's nature and I think he found it a bit difficult to direct people. In my opinion he should have been a lot firmer, especially when dealing with a SMT who have a difficult history.

161) Personally, I did not feel that I could rely upon the other Senior Managers during the Relevant Period. This is mainly because I had not developed trust with them as you need in a professional relationship. I got on with them, but I had not developed trust in them. I always made sure I was doing my role without the need to have to rely on others. I of course knew there were difficulties within the SMT when I joined but it was a challenge I wanted to try and fix.

162) During the Relevant Period I was responsible for the functional heads such as Juls Williams, Michelle and the Head of Security at the time. All of these individuals were

part of the SMT. I conducted appraisals with those I was responsible for and did what I could to manage them appropriately.

163) We would have carried out a yearly training needs analysis and based our training from that need. I, however, have no records to refer to any outcomes. I do recall suggesting that it would be good for the development of some of the functional heads to go and look around different custodial environments but some of the functional heads decided they did not want to do this.

164) After Panorama aired, Lee Hanford (**'Lee'**) came to Brook House and took on the role of Director approximately three or four weeks after Ben Saunders left. It is my understanding that, during the Relevant Period, Lee worked at HMP Parc as 'Business Innovation Lead'. I have known Lee for some time as I have attended previous courses with him and worked with him in the prison service. Lee was highly regarded. He understood the dynamics around mobilisation of contracts. Lee and I were not friends per se, but we had a good professional working relationship. Lee reported to Jerry Petherick, G4S Senior Management.

165) I have known Jerry for many years. I knew him in the prison service and we crossed paths again when I was working up in Birmingham because he was working for G4S. We had a professional relationship. I didn't have to report to him, however, I had meetings with him every month to discuss training reviews. I didn't socialise with him externally outside of work.

Relationship with Junior Staff

166) DCOs are accredited by the Home Office and they carry out a variety of roles within Brook House that assist in the care and support of managing detainees. I always say that after doing an ITC, it is a learning process on the job. My personal view is that it will take up to six months before new DCOs feel experienced and comfortable with the environment.

167) DCMs are also known as first line managers. They are in post to oversee the first line management of the services of Brook House, ensure compliance with protocols and procedures, and manage staff. They have line manager responsibilities and may be required to work in different roles.

168) I did not directly manage any DCOs or DCMs. During the Relevant Period, it was my observation that there seemed to be a clear separation between DCOs and DCMs and it was very much a 'them and us' culture between the two roles.

Management of DCOs and DCMs

169) As discussed throughout this statement, I would often meet junior members of staff during the morning meetings and every time I did a walk around. This was on a daily basis when I was on duty. This would enable me to be kept abreast of what was going on and also be visible. If there were any messages that I wanted to covey, the morning meeting would be my opportunity to do so.

170) I have reviewed the transcript of Santiago Rodriguez-Cuso's Kate Lampard interview at page 66 of document **VER000292** in which he comments that I do not give enough support and was not present enough. I would have to disagree with his comments. This appears to be his opinion, but as far as I am concerned, it is an unfounded opinion.

171) The SMT meeting minutes dated 9 February 2017 **CJS000555** records that DCMs are to be briefed by myself each morning about expectations for the day. My daily expectations would be that we get through the day without issues and all areas are appropriately staffed. The briefing referred to here was an informal meeting which directly followed the morning briefings with all staff, taking place straight after the morning briefing had finished, usually 8:30am, however, as it was informal, there was no set time that it took place. In addition to this, there was no set attendance numbers. The number of staff members who attended would depend on how many DCMs were on shift. During these meetings we could discuss operations for the day and catch up on any concerns. It was an opportunity for the DCMs to raise any issues with me.

172) I believe that these informal meetings were effective to a point. People could sit down and raise concerns and it was access to me on a daily basis for the DCMs.

173) Document **CJS000917** is Gatwick IRC Security Meeting minutes dated 11/05/2017. The note records that "*SS briefs daily that DCMs go onto the wings*". I would ensure that the DCMs complied with this direction by laying out the expectation that, if a member of staff worked on a wing, they must manage it and this includes the need to be visible on the wing and approachable. There was also a residential manager that was expected to ensure that staff were doing what is expected of them. The Residential Manager would talk to me if they felt that the DCMs were not visible and doing their jobs.

174) I can see that, within document **CJS000536**, my Deputy Director's update states "*key focus on DCMs and that they need to support their staff. SS [Steve Skitt] has a morning meeting with the DCMs to reinforce what the daily requirements from the DCM team*." The reason behind this update was because, from memory, there was certainly feedback from various sources that some DCOs did not feel supported in their areas by DCMs. While I cannot recall exactly, I would imagine that comments would have been made by staff to this effect and this is how the issues came to my attention.

175) The role of an Oscar 1 relates to incident management. They operate the day to day running of the centre and are responsible for dealing with an incident and its aftermath with reporting procedures. If there was a vacancy for the Oscar 1 role then we would ask for nominations from DCMs who wished to become an Oscar 1. If a DCM wants to become an Oscar 1, they would then need to apply for the role.

176) During the Relevant Period, I thought the Oscar 1s were capable and I never had any concerns. If I had had concerns about the capabilities of these individuals, I would have reported my concerns through the correct channels.

177) James Begg was the Safer Community DCM at Brook House during the Relevant Period. DCM Begg was very good at his job. He was a very motivated individual and was keen on safety.

178) Zeeshan Qayyum (**'Zeeshan'**) was the Head of Religious Affairs at Brook House during the Relevant Period. I feel that I had a positive working relationship with him. He came to Brook House with good ideas. There were a few small issues around his time keeping that we raised with him and tried to help him manage it a bit better. I have been referred to document **CJS0073022** by the Inquiry to provide further comment on Zeeshan. Zeeshan was disciplined for sleeping on duty on 2 August 2017. Upon a review of document **CJS0073022,** I note that, within his disciplinary hearing, he mentioned speaking to me and told the chair of the meeting that it was agreed that he could start work between 8.00am and 8.30am to avoid the traffic on his journey into work. I vaguely remember this discussion. Zeeshan was finding it difficult to get trains into work. I subsequently agreed an adapted shift time with him so it was easier for him to travel to work. This was a verbal agreement. As long as he was there for morning meetings, I was flexible. I can only imagine that any delay in implementing this was due to the fact that I needed to talk formally with him, which was only when the solution became apparent.

179) I have been asked to review paragraph 48 of document **INN000007,** the Rule 9 witness statement of Owen Syred (**'Owen'**). Within this paragraph, I note that Owen stated that *"[A] policy was introduced at Brook House that stopped DCOs taking their meals on the Wings [...]".* The Gatwick IRC contract specified that the kitchen would provide a certain amount of meals per day for staff to eat. If staff wanted these meals they had to sit down and eat their meals with the residents. It became clear that staff were coming in and taking food off the wing to have for their dinner later. They were not eating the food in accordance with how they should be under the contract and the system was being abused. It is my opinion that if this process had been adhered to, it would be a good system to have staff members eating alongside detainees. This was agreed action taken following discussions amongst the SMT.

180) I have been provided with document **IMB000048** by the Inquiry which contains meeting minutes of the IMB on the week commencing 7 July 2017. I have specifically been referred to the comments recorded in relation to 'destitute tobacco'. Destitute tobacco is effectively a management tool to help detainees who are addicted to smoking or who are going through a crisis. In some cases you can give these residents cigarettes as an appeasement tool. It was my view that some managers were starting to rely too strongly on management through appeasement with tobacco.

181) Document **IMB000048** records that I stopped the practice because I was not aware of it, and because it had been costing up to £250 pounds per month. In relation to the first point, I can confirm that I was aware of this practice. We did not stop the practice completely, we simply implemented a requirement that a manager needed to get authorisation from myself if they wanted to give residents a cigarette. In relation to the second point, the DCOs would get the cigarettes from the internal shop. We would have a log from the shops at the end of each month which totalled how much money was being spent on cigarettes for these purposes. This was agreed action taken following discussions amongst the SMT.

182) While I agree that 'destitute tobacco' was a helpful management tool, the process was being abused and people were having 20 cigarettes a day from it. This is costly. Managers were finding it too easy to keep detainees quiet with cigarettes.

Relationship with Healthcare Staff

183) I would attend the monthly commissioner meetings which some healthcare staff also attended. Some of the healthcare staff would also be present, on occasion, in the morning briefings. If I had any concerns I would speak with the healthcare team separately. I would not say I was in daily communication with them.

184) I have been provided with document **VER000277** by the Inquiry and have been asked to comment on the statement made by Dan Haughton (**'Dan'**), Support Services Manager, in his Kate Lampard interview that *"[third party welfare organisations] never*

fully came over to me, so Steve Skitt kept hold of healthcare, and Aramark." As stated above, I would be the normal point of contact for the Healthcare Manager. I also sat in on the quarterly Healthcare Commissioners meetings. The statement Dan has made was the policy at the time. It was accepted that I was the main contact with healthcare rather than Dan. Dan was in a role that had been made up to some extent and it was a new role. I had always had oversight of healthcare since I became Deputy Director.

185) Members of the healthcare team would be present during Use of Force incidents to respond to any medical emergencies and to provide advice on any medical concerns regarding the resident involved.

186) The Inquiry has referred me to document paragraph 204 of **VER000261** and asked me to provide details in relation to the 'role of the nurse' talk with regard to control and restraint. On my reading of this document, I cannot see this mentioned. In any event, I should be able to provide comment on the same. During the Relevant Period, there were quite a lot of nurses who had not worked at Brook House for very long. From memory, I recall that there was a comment raised about what nurses should do around a planned Use of Force. It was therefore agreed that nurses should be given oversight into planned and non-planned Use of Force because they are the medical expert. They need to observe the resident to make sure that there are no medical issues. In such circumstances, they would tell the supervisor that there is a medical emergency and appropriate action would be taken. The 'role of the nurse talk' was not formal training.

187) I do not recall having any concerns about the effectiveness of their involvement here, nor the attitude of healthcare staff towards detained persons. If I did have any concerns I would have raised them at the time.

188) I would often discuss residents with ongoing medical needs with the healthcare team so that I was regularly updated with where the resident was with his medication and, if they were in hospital, how long they were likely to be there for.

Relationship with the Home Office

189) I liaised with the Home Office because of the compliance side of my role as Deputy Director. I was very familiar with them and we would have monthly meetings with them to discuss compliance matters, or any general queries or matters either party wanted to raise. All of these meetings were minuted by the Home Office.

190) Every week I had a meeting with Paul. One of our main KPI failures was getting residents to meetings on time. I never knew about these failures until after they had happened. I could be asked to review the reasons for the failures.

191) I actually put new systems in place during my time as Deputy Director because the Home Office used to attend meetings and raise an issue they had about something that happened two to three weeks prior. To try and investigate such historic matters like this is extremely difficult. As such, I put in place a new system of self-reporting which is still in place today. If we, as the contract, do not get something right, we self-report, rather than wait for them to be reported to us retrospectively.

192) The Home Office had a very small team that were based at Brook House during the Relevant Period, however, I do not believe that they were there to be the case workers of the residents. This was my interpretation of the services they were there to provide anyway.

193) I have looked at document **VER000256** as requested by the Inquiry. I remain of the belief that my relationship with the Home Office staff was both positive and professional. I was approachable to them and they were approachable to me.

194) I believe my comments are clear within document **INQ000077** in relation to my view of the operational knowledge of the Home Office staff, however, I emphasise that this was a simple observation I made. I was not looking to be overly critical. The operational knowledge is effectively the difference between what we do and what they do. They are not operational staff and they perhaps may not understand the day to day operation as clearly as I would.

195) I have been referred to page 54 of document **VER000292** by the Inquiry and I have been asked to comment on the note recorded in relation to Paul, saying "*Concern with Steve Skitt...no ownership of probs*". My comment on this would be that this is Paul's opinion. I have heard comments about myself in the past relating to not seeming to have an interest, but this is not the case. I believe this may be down to the way in which I process information and how that may be interpreted.

196) Having considered paragraph 141 of document **VER000248**, I am satisfied that this would have been what I said in my interview with Kate Lampard. From my perspective, the difficulties in operating IRCs can link to the lack of knowledge you have about the cases of the residents. When a resident asks you a question, you sometimes cannot give them an answer. This fuels their frustration. For example, at present with COVID-19, we have a lot of people who want to go but they can't because the borders have been closed. If you cannot give these individuals a response or an update, it causes frustration. They're just being batted from pillar to post. It would be nice to be in the position where you have the information to give a resident an answer when they ask you questions and provide clarity to them. You would solve a lot of problems by having even a small amount of information to give them.

197) The Inquiry has asked me to explain 'whether and why (I) consider, in retrospect, that the work in the Gatwick IRCs is more around social care than prison work'. I do not think that the work in the IRC is more like social work than prison work. What I will say is that they are very similar environments. Social care, in my opinion, involves dealing with people who are more vulnerable, who may have learning disabilities and mental health issues. What you are presented with here in the IRC is no different. There is of course a lower proportion of people with social care needs in the IRC, however, I believe that the preventative measures taken in relation to mental health issues is better within the IRC.

Meetings

198) I have been provided with, and reviewed, documents **CJS004230** and **CJS000582.** Document **CJS000582** is a G4S weekly bulletin for the week commencing 10 April 2017. **CJS000582** contains meeting minutes of an SMT meeting on 13 April 2017.

199) I cannot specifically recall whether I attended the Trading Review in Birmingham with Ben on 12 April 2017 as this was almost five years ago. I did, however, attend most Trading Reviews. They took place every month. If my whereabouts was recorded as being in Birmingham on the same day as Ben on 12 April 2017, which I can see it was on document **CJS004230**, then it is a reasonable assumption to presume I was there. Due to the period of time that has passed, I cannot comment on what input I may have had in the Trading Review, whether recruitment was specifically discussed at this Trading Review or provide an opinion as to how this particular Trading Review went. I am also unable to comment on how receptive G4S leadership was to suggestions/changes and/or challenges at this specific Trading Review for the same reasons. In terms of Trading Reviews generally, I cannot recall a time when G4S leadership pushed back on any specific suggestions.

200) Documents **CJS004147** and **CJS004187** are both weekly bulletins, respectively dated 26 June 2017 and 21 August 2017. Both of these documents record that I attended Detainee Consultative meetings during those weeks. The purpose of Detainee Consultative meetings was to meet with the residents and they could discuss matters with you, for example, raise concerns or talk about regimes. Most departments including the Home Office attended this meeting. These meetings were very informal and, if I remember correctly, they were ran monthly. If I was in attendance at these meetings, I would assume that I was the one running the meeting. I feel that the meetings were good because it allowed the residents to get their frustrations out, however, at lot of frustration was aimed at the Home Office, Healthcare and the food provided and the meetings had a tendency to cause friction. Residents would often speak of their personal problems and that was not the purpose of the meetings.

201) Within document **IMB000026,** I can see that I am recorded to have said that wing forums had been taking place on each wing weekly, with G4S and the Home Office

present. These were different to the wing surgeries referred to within document **IMB000077.** The purpose of these meetings was to talk about what was going on in the wing with the detainees. I had no involvement in these meetings and cannot recall when they commenced, I just knew they were taking place weekly during the Relevant Period. I am aware that food adjustments were made further to the complaints raised in some of these meetings, and so the meetings were effective in that sense.

202) I cannot remember exactly when, but I introduced the Detainee of Interest training/meetings. I know it was before Panorama aired. The reason for this was because there were a number of detainees in the centre who were problematic. We identified them as 'detainees of interest'. The weekly meetings provided the opportunity for all teams (including healthcare) to attend a meeting where we would discuss these detainees and put an action plan in place for monitoring and controlling them. I chaired these meetings when they first started, but Michelle took over this role. In my opinion, these meetings were effective. It was a good line of communication between teams and meant we were open and transparent, which is very important in a multidisciplinary team.

203) Document **CJS000462,** minutes of an SMT meeting dated 23 August 2016, records that I would review the Terms of Reference ('**TOR**') for the Detainee of Interest meeting. I am also recorded to have said we needed to ensure that the right people attended. Here, when I say 'right people' I was referring to staff members from the right departments, for example, healthcare, residential, security etc. I was not referring to specific individuals.

204) The Excessive Disruptive Behaviour meetings, as mentioned in document **IMB0000015,** were chaired by a senior individual in the Home Office, such as Alan Gibson. Within the meetings, which were via a call, we would discuss individuals who were causing excessive disruptive behaviour and what action could be taken in response to this. The immigration team would discuss these individuals and determine whether they should be moved to a different detention centre. All centres had to provide a list of residents who we wanted to be considered, to the Home Office. Within these meetings

I would then talk through why we nominated these specific residents and summarise their associated issues. Other attendees at this meeting would include case workers and other representatives from the Home Office.

Disciplinary and Grievance Process

Disciplinary Process

Disciplinary processes: other employees

205) My involvement in the disciplinary process was to either set TOR for an investigation if I was to be the hearings officer, or carry out disciplinary meetings based on the findings of any investigation, having been provided with the TOR by another member of staff. I cannot recite specific examples from memory alone, however these would have all been formally recorded.

206) There is only one disciplinary that sticks out in my mind and it involved a staff member using Use of Force. It was alleged that the staff member purposely stood on the detainee's foot. When interviewed the staff member gave a different story but there was CCTV evidence available to us to review what happened. I'm unsure whether this was during the Relevant Period. From memory I don't think it was.

207) I have noticed a document titled **CJS000473** which the Inquiry have given me access to. I note that this document contains a table which relates to some disciplinary processes of staff members in 2017.

208) I also note that the Inquiry have provided me with a number of documents relating to disciplinary action of staff members which I was involved in. I provide comment on these below at paragraphs 214) to 223). While it is difficult to recall all the details of these specific incidents, I believe that, where I was involved in the disciplinary of other staff members, they were dealt with appropriately and lessons were learned.

Overview of Disciplinary Process

209) The disciplinary process can be instigated via many means, for example staff can put in confidential SIRs and residents can put in complaints. Any potential disciplinary issues could be brought to our attention via the same means. I have been referred to paragraphs 406-407 of document **VER000256** by the Inquiry and my comment would be that any alleged inappropriate behaviour of staff will be reviewed by either the PSU or ourselves.

210) I could be asked to conduct an investigation, hear the outcome of an investigation or commission an investigation following receipt of information that may amount to a disciplinary issue. Assuming our records are correct, looking to document **CJS000473,** I was involved in around eight disciplinary investigations within the Relevant Period.

211) When I have been involved in the disciplinary process for other staff members, it is my observation that staff are fearful that the outcome may be dismissal from the organisation. I am someone who has been subject to a disciplinary, as detailed within this statement, and it can make you fearful. I do not think there was a general fear amongst staff of losing their jobs other than in these specific circumstances.

212) I have been provided with documents **VER000247** (paragraph 133), **CJS0073334** (page 2), **CJS0073348** and **CJS0073621** by the Inquiry and have been asked to describe my involvement in disciplinary matters at Brook House. I believe that it is quite clear within the documents themselves what my involvement was. I have also discussed what my involvement might be generally within the paragraph above and provide specific comment on a number of previous disciplinary matters below in paragraphs 214) to 223).

213) The Inquiry have referred me to documents **CJS0073137, CJS0073221** and **CJS0073311** which relate to the disciplinary process of Steven Payne. On review of the documents, I chaired the disciplinary hearing. I took the decision to dismiss him and was assisted by HR throughout the disciplinary process. He then appealed this decision

and the appeal was upheld. Upon consideration of document **CJS0073137,** I can see that Steven Payne questioned the impartiality of the decision within his appeal letter. This letter was sent to Lee and I do not think that I would have seen this letter or these allegations for this reason. Furthermore, I did not chair his appeal hearing and so would not have been privy to his concerns about impartiality. I believe that HR and I acted in accordance with our policies and procedures at all times.

Specific Examples of my involvement in the disciplinary action of other staff members

214) I have considered documents **CJS0072966,** a disciplinary meeting outcome in relation to Ben Shadbolt, and **VER000238,** the transcript of Ryan Harkness' (**'Ryan'**) interview with Kate Lampard. I do not specifically remember this as it was in September 2016, and so I cannot really provide any further details over and above that contained within document **CJS0072966.** On review of the documentation, clearly there was an issue and we had the meeting to discuss it. I can only assume that I accepted that there were issues internally, namely lack of training and support, and took this into account as his mitigation. This was taken into consideration when deciding what disciplinary sanction to apply. I made the decision to advise him on what he needed to do next (i.e. speak to his line manager in his one to ones etc.) rather than giving a written warning. I imagine I would have also told him to ask the next time he was unsure of something and not to sit in silence. I am always on hand to provide advice and guidance.

215) I have been provided with documents **CJS0073473** and **CJS0073525,** they relate to my involvement in disciplinary action taken against Steve Dix in February 2017. I recall that this involved an SIR, which I believe he posted out to a member of staff. He essentially passed on confidential information that he should not have done. I conducted the hearing. I think the outcome was a 12 month written warning. This is towards the lower end of the spectrum for possible enforcement action. I think he learned his lesson from this incident as it is my understanding that he found the whole thing to be quite embarrassing for him.

216) I have been provided with documents **CJS0073348**, **CJS0073363**, **HOM005374** and **CJS0073621** by the Inquiry which relate to a disciplinary investigation into the conduct of DCM Ian Macdonald after a detained person removed the handcuffs on a hospital escort on 4 March 2017. Upon consideration of these documents, I can see that I chaired the disciplinary meeting with Ian Macdonald and I issued him with a final warning. I considered all the evidence before me and came to, what I consider to be, a balanced decision, following company processes and procedures at all times.

217) Documents **CJS0073060**, **CJS0073014**, and **CJS0073300** relate to a disciplinary investigation into an allegation by DCO Shayne Munroe in 2016 that she had been called a "f*****g black c**t" by DCO Spark. On review of these documents, I would not really be able to provide much comment over and above what is contained within the documents themselves. I conducted the disciplinary investigation and concluded that an altercation occurred but I could not establish that racist comments were made. It was a typical 'one word against another' situation. It was clear, however, that both members of staff were derogatory towards each other. I issued written warnings to both DCO Munroe and DCO Spark and instructed them to undergo mediation because, at the end of the day, both members of staff have to continue working in the same place and it is important that any differences are resolved to make sure there is a supportive environment.

218) I was responsible for the disciplinary investigation into DCO Shayne Munroe in 2017. I believe documents **CJS001594**, **CJS005888**, **CJS005880**, **CJS005874**, **CJS005894**, and **CJS005896** relate to this investigation. DCO Munroe was in the wing office and a resident who came in became very challenging. I conducted an investigation in accordance with the policies and procedures in place at the time and taking all of the circumstances into account, I took the decision to dismiss her with immediate effect. The Panorama programme had aired not long before this, however, this had no impact whatsoever on my decision making process. I would have made the same decision whether it was before or after Panorama aired.

219) I have reviewed documents **CJS005880**, **CJS005889**, **CJS0073303**, **CJS0072930** and **CJS0072900** and these relate to the disciplinary investigation into DCO Fagbo. I remember that I conducted the disciplinary investigation on this occasion. I recall that I adjourned the hearing to review the CCTV footage to see whether he could have just walked away from the situation. I conducted an investigation in accordance with the policies and procedures in place at the time and taking all of the circumstances into account, I took the decision to dismiss DCO Fagbo for gross misconduct. The forthcoming Panorama broadcast had no impact whatsoever on my decision making process. I had reasonable grounds to dismiss in accordance with the company policies and procedures in place.

220) On review of document **CJS0073603**, I can see that Jack Davey's disciplinary outcome letter was sent by myself. Within this letter I can see that I say "*we have detainees in our care and we have our G4S core values [...]*". I have outlined these core values at paragraph 44) of this statement. It is expected of all staff on duty that they will carry out their duties professionally, in accordance with G4S' core values and put the needs of the residents at the forefront of how they work.

221) Having had the time to consider documents **CJS0073379**, **CJS0073156** and **CJS0073137,** I can see that I was involved in the disciplinary investigation into Graham Purnell in 2018. This appears to be outside of the Relevant Period, however, I can confirm that I held the disciplinary hearing. I conducted an investigation in accordance with the policies and procedures in place at the time and taking all of the circumstances into account, I took the decision to dismiss him. I believe that this outcome was entirely appropriate. I do not recall being aware of any other allegations against Graham Purnell at this time.

222) I have reviewed documents **CJS0073584** and **CJS0073207** and these relate to the disciplinary action taken against DCO Gary Siggins regarding inappropriate comments towards a detained person. Having read these documents, I can see that I chaired the disciplinary meeting and I took the decision to dismiss him. Once more, I believe this to have been a reasonable decision based on the investigation conducted. In my view I

applied the policies and procedures as I had done previously and Panorama had no impact upon the decision making process.

223) I have been asked by the Inquiry to comment on the allegations made against me by DCO Gary Siggins within document **VER000265.** Members of staff at the centre spent a great deal of time helping Gary Siggins out with his issues. I can see that DCO Siggins makes a comment that he was working out of ticket and I would not be able to comment on that. All I would say is that, if someone was not in ticket, then we would put them in resident non-facing roles.

Disciplinary processes: personal

224) I can only recall a couple of occasions in which I was personally investigated. One was the result of an (unfounded) allegation against me by another staff member. I believe that this was not during the Relevant Period. The allegations against me were not upheld.

225) I have been referred to document **VER000239** by the Inquiry. I understand this document to be the transcript of the Kate Lampard interview with Lee. I have specifically been referred to paragraph 43 of this document at which Lee says "*He is someone who is willing to adapt to new ways of working. My early discussions with Steve, for example, I'm about to overturn his dismissal this week as an example.*" I have been asked by the Inquiry to 'explain whether and why I was dismissed and why it was overturned'. I can confirm that I have never been dismissed for anything. I also have no knowledge of any intended dismissal. I certainly never attended any dismissal related interviews. The only interview I attended post the airing of Panorama was the one with Kate Lampard. Having reviewed the document **VER000239**, it appears that Lee is referring to a decision I took to dismiss someone else, which he then overturned. The question asked of me by the Inquiry appears to be a misinterpretation of the transcript.

Grievance Process

Grievance process: other employees

226) Similar to the above, I may have held meetings in relation to the grievance processes of other staff members, however, I am unable to recall any specific details.

Grievance process: personal

227) I have had a small number of grievances raised against me, maybe three or four, while working at Brook House. I mentioned this within my interview with Kate Lampard [**VER000248**, paragraph 52]. I have provided comment on these towards the end of my statement at paragraphs 394) to 420). None of them have been upheld.

228) Within my Kate Lampard interview, I commented that "*every individual who's put a grievance in [*against me*] is somebody that I've challenged for either corrupt or poor behaviour, or performance behaviour*". 'Corrupt or poor behaviour' can mean many things, but to provide an example, this could be making expense claims that are not warranted. Where I refer to 'performance behaviour', this again could mean many things, but examples include staff members not being where they are meant to be, turning up late/leaving early, not doing their job properly or general poor attitude or performance. Within my interview, I mentioned that there was a "*long difficult one going on*" and this was an occasion in which someone raised a grievance against me. The grievance was investigated by an external investigator and then that same employee raised a grievance against the external investigator.

229) One example of an instance where I challenged the types of behaviours outlined above was an occasion in which an employee was claiming expenses for a training session that he told us he was attending. He was submitting expenses for parking tickets and fuel. But I had a call from the training provider to say that he had not been attending. When I looked into the claims he was submitting, I discovered that they were for other reasons, for example one claim for a parking ticket was for parking for a night out as it

started at 7:00pm until the early hours of the morning. Once I discovered this, I commissioned an investigation into him. The employee resigned in response to the challenge.

230) In my 30 years of working, I have never had a grievance raised against me until I commenced employment at Brook House. I do believe that there was a culture of raising grievances at that time, as referred to at paragraph 38) of this statement.

Staffing Levels

231) I have been reminded by the Inquiry that G4S was contracted to provide 668 hours of DCO time per day and that the contract required at least two DCOs on duty in each residential wing throughout the day.

232) In terms of whether this level of staffing was adequate, you can argue it both ways. It all depends on what is going on at the centre. At times, I accept that it could be very tight, however, on some days there was more staff than the minimum contracted levels. Scope for cover was limited in my view because, if a DCO was called to assist in a Use of Force incident, this would mean they had to leave their residential wing (if that is where they were based) and it was often difficult to find cover for this individual while they were out assisting in the Use of Force, but also in the period after the Use of Force when they had to write up their report. At key lock up and unlock times, we would have activities and education staff who would report to the wings to ensure a greater number of staff at unlocked times. Once activities started, the level of residents present on the wings would reduce as they were out of the wings completing activities in the activity areas (e.g. gymnasium, library, IT room).

233) Technically, having two DCOs on a wing where 120 residents reside could be challenging. However, I was aware of the contract levels and so I often thought that we just had to make do with what we had.

234) I am aware, on a number of occasions, both formally, through the POA representatives, and by staff, that staffing levels was a concern to them. I think I recall that this would have been discussed at some SMT meetings.

235) I was involved in some staffing plans, particularly the one I can recall was surrounding the extra 60 beds that were put in place. I was also involved with working with the, then, Director, and others, and I can recall that everyone who was involved in this process at the time considered the plan, and agreed the staffing levels would be deemed appropriate.

236) I did have input into the September 2017 review of staffing arrangements. I have been provided with document **CJS000736** by the Inquiry which is a three month action plan dated 15 September 2017. I was aware of this and believe I was consulted on it. I believe all the action points allocated to me were actioned.

237) I am always conscious of staff safety and, whilst I am not saying it did, I understand there could always be the potential for the staffing levels, when they were tight, to have an impact on the health and safety of residents and staff. However, you could put six staff on wing and they could still feel unsafe. It is a difficult thing to configure. It is also important to look at the true context. While 120 residents may have been housed in a wing during the Relevant Period, a lot of the residents would not be on the wing during the day.

238) The problem we had in the centre is that we were constantly having to move resource around. It was also difficult when staff put their own colleagues at risk by disappearing off a wing to go and do something without trying to find cover, therefore leaving their colleague on their own.

239) I believe that staff and residents were safe at all times despite what some will describe as challenging staffing levels. I say this because there is a first response procedure in place. Staff have the opportunity to raise a first response if at any time they feel unsafe. I am always concerned about staff, but had no concerns above and beyond the normal

concerns one would have and this was alleviated by knowing that staff had first response available. However, I am not disputing that sometimes it would be challenging, I accept that.

240) I appreciate that I might have a different perspective of the safety element due to my experience working on prison wings which housed extremely dangerous individuals with less CCTV around.

241) I cannot recall any specific issues or concerns of the staffing levels for the Healthcare team and I therefore cannot comment whether there was any impact on residents medical and welfare needs being met. In any event, if healthcare had any difficulties with staffing levels they could use bank staff. As far as I know, there were adequate numbers.

242) I believe that the activities team was as well staffed at is could have been during the Relevant Period. I do not believe that staffing levels would have impacted residents because all of the activity areas available at that time were open. Staffing levels would not have impacted upon the facilities available.

243) We could see the staffing levels everyday as we provided a clocked hours report. These records will still be held by someone I am sure. The contracted hours were set by the contract with the Home Office as far as I understand. It was a very strange system in my opinion as it appeared to be based on the hours at certain parts of the core day. I am more familiar with the system of needing a certain number of people in the centre, rather than a certain number of hours. In my opinion, it was a really overcomplicated process of doing it but that's seemingly what the Home Office wanted. This is now changed under the contract with Serco and it is much better for it.

244) In my opinion and experience, we would never maintain staffing levels below the contractual requirement to save costs. There may have been other factors that would have contributed to staffing levels below the contractual requirement.

245) There are a lot more staff around now.

246) I have had the opportunity to review document **VER000227,** the transcript of John Kench's interview with Kate Lampard, and can see that he speaks about '32 staff members'. Contractually, we had to provide a certain number of timed clock hours per day. I am not sure whether 32 staff equates to the minimum based on those hours off the top of my head. I do not recall having a discussion with Ben about any profile which reduced the number of staff to 32 and so I would be unable to comment on this.

247) I have been asked to confirm whether I agree with Sarah's assessment at paragraphs 276-282 of document **VER000223.** Sarah mentioned Nathan Ward within these paragraphs and I believe I started working at Brook House after he left and so I can only assume that I would not have been around when those discussions were taking place. I have noted Sarah's comment at paragraph 279 about profit. Sarah says that there was only a small profit built in to the contract. I know this can be a subjective point, but it was my view that the Gatwick contract was very profitable for G4S.

248) I have considered document **CJS000575,** which contains meeting minutes of an SMT meeting on 3 May 2017. I believe the sickness policy and unauthorised absence policy are managed separately. The only comments I could provide on the contents of these minutes with respect to staff absences would be that I believe our discussion centred on the triggers for absence. During the Relevant Period, staff would often go AWOL rather than off sick. This was because if a staff member went AWOL, they would only lose a day's pay and then they could then just do a day's overtime to make up for it.

249) The Inquiry have provided me with document **CJS0073169** which is a letter from myself to Nicola Kaminski (**'Nicola'**) dated 7 December 2016. Nicola raised concerns about being called to search female visitors. The issue stemmed from detailing a male and female in the satellite gate. I cannot recall if I did follow through on this or not. If it was about detailing, I would have made a phone call or email actioning it.

250) Re-profiling is carried out so that a business can understand what work they carry out and the staffing levels/roles required to complete that work. The business is measured over a 24 hour period. This will then enable you to understand what staff you require and how many. You can then put together a shift pattern from this analysis. I did not have much involvement in this and I cannot remember how often re-profiling was carried out in the Relevant Period.

Recruitment

251) I would not have been necessarily involved directly with staff recruitment (including ACOs, DCOs and DCMs), this is usually dealt with by HR. However, I am aware that all staff that did apply to join Brook House would have to take an assessment day and I may have, on occasion, been required to meet with these potential new staff and give an overview of the role they were applying for. I'm not aware at what stage the motivational fit for each candidate is assessed.

252) On review of document **VER000238**, I recall that I interviewed Ryan Harkness with Sarah Newland. I cannot remember whether this was for a generic DCM role or the specific DCM role referred to by Ryan within his Kate Lampard interview [**VER000238**]. Ryan did, however, go through a formal promotion process. Ryan was originally recruited as a DCO. When he arrived it was clear that he was very passionate about cleanliness. The person who was currently in the DCM role Ryan moved to was demoted. Ryan's promotion to DCM would have been discussed with other members of the SMT and a decision would have been made jointly. I cannot remember if the role was advertised internally or externally as I would not have been part of the process of advertising the role. I also cannot recall how many people applied for the role as, once more, I would not be involved during the initial stages of the recruitment process.

253) I have noted within document **VER000238** that Ryan says he asked for training once he commenced his new role, but that it was not provided. I recall that Ryan was very self-motivated in what he wanted to do. From memory alone, I do not remember a specific conversation where I discussed this with Ryan, but this training would have

been something that Juls was responsible for providing. In his new role as DCM, Ryan would have needed to be compliant with the DSO, understand the process and the policy guidance and understand the systems in place. I would also have expected there to have been some sort of handover from Ryan's predecessor in the role.

254) I do know that it could be challenging to recruit at times, but we were always able to recruit staff to posts. The salary and the overall package, in my opinion, was consistent with other custodial roles in other organisations. The difficulties experienced at times with recruitment I believe, reflected the employment in the area where Brook House is located. Brook House is right next to an airport where jobs are often advertised. If places like the airport were recruiting, you found that numbers applying would decrease, but when they were not recruiting, numbers would rise. It really did fluctuate. We did, however attract candidates who had worked in other custodial settings to work at Brook House.

255) In my opinion, as with most roles, working within this environment, a larger salary and reduced hourly week, would maybe have improved retention rates.

Retention

256) In my opinion, given the location we operate in, it has very affluent and fast employment opportunities. Where people would see roles being offered for more money, working in a different environment, and without the challenges that are apparent in this field of work, sometimes this will appeal to them. It will mainly be staff in the role of DCO who would be leaving the business for these reasons. We also recruited and still do, staff who live some way from Gatwick and if they found roles within their local area, they may leave to take this up.

257) I joined the prison service in 1986 and saw it as being a job for life. Personally, I do not think the job market is like that nowadays. I think people move between jobs a lot more now and many people do not see this job as a 'career'. They see it as a job and then try for a 'career' in the Police or prison service.

258) A new contract was introduced in early 2017 which requested staff to work a 46 hour week consisting of 13.5 hour shifts. In my understanding, staff preferred to work the 13.5 hour shifts and it was their preference. I believe that, in their view, this gave them a better work life balance. The reduction from a 48-hour week to a 46-hour week had a positive impact amongst staff but I am unsure whether this had an impact on staff retention.

259) There are a number of initiatives that have been rolled out within the new contract which I believe has improved retention hours of work, greater staffing levels, employee partnership forum run by staff to raise issues to the SMT, suggest and raise ideas. at Brook House, however, as above, we work in a location where the employment market is buoyant giving staff the opportunity to move to other roles that may attract more money or maybe more convenient in regards to location for staff.

260) At paragraph 58 of document **VER000220,** I note that Caz suggests that Brook House "*should be focussing on retention rather than recruitment*". I do not disagree with this view. This was discussed at the Trading Review in April 2017 and we had a retention policy drawn up after that.

Tinsley House Staff

261) All DCOs, whether they worked at Brook House or Tinsley House, had undergone the same training, however, I understand there is a difference between both sites. It was clear that the Tinsley House staff preferred not to work at Brook House, or be cross deployed to other centres, as physically they were different to Tinsley House and in some ways operated different processes and systems.

262) I understand staff's concerns with being cross deployed to other centres and if, for example, we cross deployed from Tinsley House to Brook House we would look at the area we would deploy those staff into. We attempted not to deploy them directly onto

residential units, however on occasion, this was unavoidable, due to operational necessity.

263) During the Relevant Period Tinsley House was being refurbished and so some Tinsley House staff worked at Brook House. I accept that there are probably aspects we could have done better regarding the Tinsley House staff, including their familiarity of Brook House. We acknowledged this and put a more inclusive familiarisation process in place

Treatment of Detained Persons

Individuals Generally

264) I was not directly involved in the Reception process for residents when they arrive in the centre and therefore cannot comment on this process.

265) I have been provided with document **CJS006042** by the Inquiry which is an induction policy. I believe that this was in use during the Relevant Period, but without a date on the document I could not be absolutely certain. This is an agreed document between us and the Home Office. I thought it was quite a robust and thorough policy. I believe it was followed as I was never alerted by anyone that it was not being followed.

266) It is clear that most of the time, when the residents speak to staff, they only want to talk about, or get information about, their case. That is their only real interest. As mentioned in paragraph 196) of this statement, we are in an unfortunate position where we cannot really do anything or help with anything to do with their case because we don't have the answers. You are in a catch twenty two. You can provide the services to look after them but sometimes you cannot provide them with the answers that they really want.

267) During the Relevant Period, I interacted with residents every time I had the opportunity to walk around the centre, which was a frequent occurrence. I would actively try to engage with residents and you would get to know some longer term detainees. As referred to at paragraph 152) of this statement, I believe I was visible to the residents. I

therefore do not agree with the comments of Stewart Davis at paragraph 152 of document **VER000260.**

Activities for Detained Persons

268) Brook House has very limited space for activities in comparison to other custodial environments I have worked at, however, we strived, with a dedicated team and teachers, to provide the best opportunities for residents that we could. I cannot recall whether a lack of activities impacted on any issues and disturbances within the centre. The activity areas provided, and courtyards, were opened morning, afternoon, and evening for all residents. There was also a cinema room, gym and games room available to residents. Within my interview with Kate Lampard and Ed Marsden [**VER000248**] I also said "*Some of the things I've identified would be using more peer support and having a better welfare facility for detainees which is more self-helping [...]*". My view was that we should have residents working in a hybrid role. This could then be used to provide support to their peers.

269) I recall that at least one of the courtyards was shut following the attempted escape of detainees in or around 2017, however, I cannot recall the specific details relating to this. I recall there being discussions between G4S and the Home Office about who would pay for extra security staff for the courtyard, but the content of these discussions is not within the remit of my knowledge.

270) We currently have a larger activities team providing more activity engagement for residents. It is a proactive team that as well as providing an agreed activities programme, is also always approachable to cater for individual needs.

271) I have been provided with document **TRN0000055** by the Inquiry, within which Callum Tulley states that I asked him to put posters around Brook House because of visitors. I cannot recall the details of this, but it sounds like something I would have said. Each department had their own notice board around the centre. If I recall correctly, when I walked past the activity notice board, I noticed that there was a lack of information on

it. The activity notice board should have a timetable for activates posted on it. Callum was the Activities Officer and so he should know that the activity boards need to have this information up for the residents to see. There was no particular reason for my request. From memory, there was no one in particular visiting the centre at that time. We regularly have visitors to the centre.

Immigration Rule 35 Process

272) I had no involvement in the Rule 35 process.

273) All Rule 35 processes were dealt with by the Healthcare provider in conjunction with the Home Office. I would therefore have no knowledge of this as I was not involved.

Use of Force

274) I was not directly involved in incidents involving the Use of Force, however, as part of the SMT I would be involved, if required, in any reviews of incidents if any concerns or issues were raised about the Use of Force. However, I cannot recall and do not have any access to information to clarify what changes were made to historical events.

275) If there had been any concerns around any incidents involving Use of Force, or in response to any complaints from residents, then these would have been investigated; either by the PSU or ourselves through the disciplinary process. However, I am unable to recall any specific incidents where this was the case due to the length of time that has passed since the Relevant Period.

276) I can confirm that I was very concerned about what I saw in the Panorama documentary. I was not previously aware of the issues aired.

277) I do not believe that the Use of Control & Restraint techniques were used excessively. I am of the opinion that Use of Force was only used as a last resort in dealing with any particular incident, when dealing with refractory residents or when we were required to

present residents for flights and transfers if they refused to leave the centre. I believe that any Use of Force would have only occurred after protracted interaction and negotiation with residents. If I had any concerns about the use of control and restraint I would have raised this without delay.

278) Other alternatives, in my opinion really revolved around staff's personal interaction with residents and using their interpersonal skills to engage with any resident and deescalate to achieve whatever the desired outcome with that resident. In my opinion this technique was used quite a lot within the centre and if I recall was very effective and, as previously explained, this left Use of Force as a last resort.

279) The Inquiry has referred me to documents **CJS005556** and **HOM0066167** which both relate to planned uses of force during the Relevant Period. I would be notified of all planned Use of Force matters as the strategy of which would always be thoroughly discussed and planned during the daily morning meetings with the wider team. I would therefore be aware of every planned Use of Force event.

280) The execution of a planned Use of Force was managed by a supervisor and overseen by the Duty Director if on site or over the phone if on call during the night. If the planned Use of Force was scheduled for during the night shift, the Duty Director would be briefed via the phone and would be on hand to assist via phone if further assistance was required at any point. The supervisor is responsible for including and ensuring all appropriate personnel are present.

281) I recall being involved in the execution of the planned Use of Force for D87 [document **HOM0066167**]. I was specifically drafted in to inform the resident that he was going to be moved. This resident had a particularly difficult and aggressive history and so, as Deputy Director, it was appropriate for me to be involved and present.

282) Unplanned Uses of Force are different as there are no prior discussions held before the intervention takes place. In these circumstances, I am either told after the incident has occurred on the same day or the next morning in the morning briefing meeting.

283) There is a special command structure within the IRC that is designated for managing serious or retracted incidents, such as those involving Use of Force. This is referred to as a 'Command Suite'. When the Command Suite is triggered, Brook House enters into what is referred to as 'Command Mode'. Within this mode there is a 'Silver Commander' who has overall responsibility and a 'Bronze Commander' underneath. The IMB are notified as soon as Command Mode is activated. The IMB are responsible for overseeing all action taken.

284) I also attend Scrutiny Meetings. Within these meetings we discuss any matters of concern and have oversight of Use of Force interventions. These meetings have been held since before the Relevant Period and are still in place. I join the meetings and contribute to discussions and decisions made. On occasion, I have been required to chair the meetings, but I cannot remember whether any of these occasions fall within the Relevant Period.

285) I do believe that the Scrutiny Meetings were effective. We would reflect on recent Use of Force events and provide recommendations for improvement. For example, if a concern is raised by a member of staff or a resident in relation to a Use of Force incident, a Scrutiny Meeting is called to review the video footage to confirm whether the officer acted in accordance with their training, and our policies and procedures.

286) I have been requested to consider document **CJS000495** by the Inquiry, the SMT meeting minutes dated 30 March 2017. The meeting notes reference "*two individual issues identified during two UoF*". From my recollection, I think this relates to incidents that involved the MMPR at Tinsley House. I cannot confirm exactly what was done in relation to these incidents but I can confirm that a dedicated MMPR coordinator was actually appointed. I am unable to confirm the exact date upon which this appointment took place.

287) The Inquiry has asked me to consider document **CJS005556** and the Use of Force incident against D434 on 23 May 2017. I can confirm that I was acting as Duty Director

on this date and I would have formally authorised this Use of Force. However, other than this, I did not have any direct involvement in this matter. Dave Aldis would have managed the Use of Force and the search would have been conducted by Callum Tully.

288) I believe that the "*relevant team*" referred to in document **IMB000003** as being responsible for completing form F213 (Report of Injury to Detainees) is the healthcare team. Healthcare staff are responsible for completing F213 forms. I cannot remember what actions were taken or discussions held following this meeting.

289) I have again reviewed Owen's statement to the Inquiry in document **INN000007**. I do not believe that control and restraint is the most important aspect of the ITC. I do consider it as being an important aspect, but it is not the most important. In my view, the control measures that come before Use of Force are equally as important, if not more so. If these measures are done correctly, it should never really come to using Use of Force. I always say that Use of Force should only ever be used as the very last resort.

290) I have reviewed document **VER000229**. I would never personally refer to control and restraint as a rite of passage. I was not aware that it was being treated as such in Brook House, nor have I ever observed this culture in the prison service. To me, control and restraint is just a part of an individual's role.

291) I have never been made aware of staff members intentionally provoking situations to detained persons so they might have to use force on them. This behaviour would be seriously frowned upon and not accepted.

292) Document **CJS000492** records "d*iscussions about body-worn cameras and appetite to enhance coverage. New BWC DCO coming out*." By way of background, Brook House historically had limited body-worn cameras. These were predominantly worn by Oscar 1s and Oscar 2s. We were successful in our attempt to obtain additional funding, and as such, were able to increase the use of body-worn cameras to other areas. Body-worn cameras are beneficial in many ways. They provide safety for staff against allegations and likewise for residents by monitoring staff behaviour. They record incidents, such

as unplanned Use of Force, and provide visual and audio evidence that can independently verify events. As such, we were discussing ways to enhance coverage further across Brook House. I think we were hoping to ensure that at least one DCO per wing had a camera and were discussing funding arrangements.

293) I have reviewed documents **CJS0073475**, **CJS0073426**, **CJS0073165** and **CJS0073245**. Disciplinary action relating to Use of Force event arises if a complaint or concern has been reported by either a resident or member of staff and a PSU investigation has found the allegation to be substantiated. The PSU Investigation Report may then suggest that G4S take action in accordance with our own disciplinary processes. In such event, someone within G4S will be appointed to convene and conduct a disciplinary hearing. The individual chairing the hearing will review the PSU's Investigation Report and determine what the correct enforcement action should be.

294) I remember chairing the disciplinary hearings for both Callan Campbell and Derek Zonias. On both occasions, I evaluated the information before me, deliberated and made what I believed to be the most appropriate decision in the circumstances in accordance with the policies and procedures.

Detained Persons' Welfare

295) I do not recall being given any training in relation to the welfare of detained persons, however, within my time in the prison service I had received mental health training on a basic level. I do have a lot of dealings with people with mental health issues when at work and I use my experiences of dealing with people when around these individuals and communicating with them.

296) I was not involved in managing the mental health and wellbeing of detained persons where healthcare was not needed and so could not provide any comment on this.

297) Where healthcare was needed to manage the mental health and wellbeing of detained persons, I would want to know about this. I have always been firm advocate that we

have local RMN teams on site and we should ask them for an assessment if we are concerned about an individual. In terms of my involvement, it would be limited, but I would want to know if there is something wrong with resident, if so, how do we treat them, get the prognosis for next couple of weeks. As Deputy Director I was interested in what the plan was moving forward and how we could deal with the resident.

298) It is hard to determine whether policies prevented drugs entering Brook House and I have provided comment on drugs entering the IRC at paragraphs 117) to 120) , however, I can recall that there were a number of drug finds - articles in the post and from rooms searches. It is very hard to determine drug supply routes into any closed facility. There are a number of ways and methods that could potentially be used, and you would work on the intelligence that you had to combat drugs entering any closed environment and base any actions on the intelligence you had which may or may not involve input from the Police.

299) I am of the opinion that residents or persons taking illegal drugs would have a negative impact on the individual, and the centre in general. However, to in order to provide a thorough response, there are a multitude of illegal substances, at the time NPS psycho -active drugs were prevalent in most custodial settings, as well as the community. No-one batch of drugs, in my opinion, was the same, and each individual would have a different reaction to these types of drugs, within any environment.

300) There was no drug rehabilitation at Brook House at the time as far as I recall. Any support that was offered would have been provided by the Healthcare services. I do not think there is any drug rehab now either.

301) I cannot recall whether the Chaplaincy team did or did not raise any concerns for detained persons with me. If they wanted to they could.

302) There was a clear policy and strategy in place for any resident who would have been deemed at risk of self-harm. This predominantly would involve the use of our Safeguarding policy and ACDT policies. In my opinion this document allowed staff to

look at all alternative support that could be offered to the resident, supporting them in their time of crisis. Part of the ACDT document is about identifying triggers. We do an initial case assessment to get more information from the individual and then it is about setting out what is best for them via a care map. This care map would then be reviewed at appropriate stages. Initially there is a crisis point requiring medical intervention to start with then it is about understanding why that person is in crisis.

303) I would not have been directly involved in the process that was followed when a detained person refused to eat the food provided by the centre, however, I am aware that, at the time, there was a food and fluid refusal policy that was in place to support and monitor residents, along with Healthcare professionals and the Home Office. I believe this was effective, but there is only so much you can do because you cannot force that person to eat against their will.

ACDT's

304) I have reviewed document **VER000260.** ACDT training is provided to staff during the ITC. Refresher training on ACDT is also provided to all staff annually. This training is provided by a qualified ACDT trainer.

305) I have been referred to documents **CJS002696** and **CJS003715** by the Inquiry. ACDTs are reviewed on a regular basis. I attend ACDT reviews when I am acting as Duty Director. I have also chaired the review on multiple occasions.

306) The reviews are conducted by a multidisciplinary team, including, but not limited to, the chaplaincy team, healthcare team, staff members on constant watch, the IMB and a Case Manager from the Home Office. My role during these reviews is to facilitate discussions between the teams in attendance with the view of reaching an agreed decision on the appropriate course of action to be taken.

307) For clarification, I have reviewed the SMT minutes dated 9 February 2017 [document **CJS000555**] and I believe that the term "*DCO*" has been incorrectly used in this

sentence. This reference is referring to a DSO rather than a specific individual who had this role (i.e. a DCO). The Food and Fluid DSO was introduced to set criteria as to when intervention can be made for someone who is refusing food and/or fluid.

308) We used to use ACDTs for every fluid and food refusal. Once the Food and Fluid DSO was implemented, there was a new rule that you would only use ACDT when the resident was protesting about Home Office detention, rather than by way of a self-harm attempt. I have discussed this previously within my statement at paragraph 53).

309) The Inquiry has provided me with document **CJS003715** which relates to an ADCT case at Brook House. My involvement in this case would have been limited to authorising the decision to take the resident off constant observation watch once he had calmed down.

310) With reference to document **INQ000077**, I have always held the opinion that some managers are at risk of being too quick in making the decision to allocate a resident to constant watch. This view stems from my previous experience in the prison service, whereby you would sit down and speak with the resident in the first instance. I believe that there are other mechanisms that can be deployed. You will find in the majority of cases that by speaking to the resident and asking the right questions very early on, you can evaluate the crisis and avoid the need to put them on constant watch.

Cleaning/Aramark

311) During the Relevant Period, Aramark had the contract to clean the centre. I cannot recall exactly when, but at some point in time, there was a lack of understanding about the wording of the contract where it said they were responsible for the association areas of the centre. We considered the 'association areas' to involve the wing areas, which they did not accept. We also had paid workers on the wings to clean them (including bathrooms and showers). Residents were responsible to keep their own bedroom clean. I believe that this is discussed in document **CJS000462.** In general, I thought the cleaning by Aramark was satisfactory. It was tidy, but it wasn't always to the standard

of cleanliness I wanted it to be. I wanted it to be cleaner. This was also noted in the SMT meeting minutes on 23 August 2016 at document **CJS000462.**

312) I have been recorded to have made comments about my stance on cleaning within my interview with Kate Lampard [**VER000248,** paragraph 220]. Discussions regarding the cleaning were held with Brian Harrison, Aramark's General Manager and we would have discussed the matters detailed in the above paragraph.

313) I have noted the comments of Debbie Weston regarding Aramark in her interview with Kate Lampard in document **VER000242.** In terms of the difference between the Home Office contract with G4S regarding the cleaning of the site and G4S' contract with Aramark over the same, I cannot remember the exact wording of the contracts. I believe that our contract wording with the Home Office was a general requirement to keep the centre clean, whereas I believe our contract with Aramark required a specific level of cleanliness. I agree with Debbie Weston's statement that: "*Our contract with G4S is for them to deliver a service and is not reliant on detainee workforce*". We should not be relying on resident workforce to keep the centre clean. We should provide them with paid work but there should not be an overreliance on this. In my opinion, we should have paid more for the Aramark contract, rather than relying on paid detainee workers.

314) The Inquiry have referred me to comments of Paul within document **VER000256,** in which he says *"Aramark were responsible for all but the residential units or wings, courtyards. The residential units and courtyards were cleaned by paid workers. That's the risk that G4S were willing to take, even if it meant that the cleaning wasn't up to perhaps the standard*". I could not provide any further comment on this as, as far as I am aware, this was something that was already in place when I arrived at Brook House.

Detained Persons as Time Served Foreign National Offenders

315) I was not involved with the Reception process and so cannot provide comment on the experience of this process for TSFNOs.

316) My approach for dealing with TSFNOs was no different to those residents what had not served a custodial sentence. In fact, my experiences gave me a greater understanding of TSFNOs within our centres.

317) I formed the opinion that mixing TSFNOs with people who had not been detained in any custodial setting could cause difficulties within those particular groups. The question of managing the welfare was not a particular concern in my opinion as I would like to believe that we treated all persons as individuals. However, TSFNOs would bring a custodial culture to this environment which I could consider could potentially have an impact on those people who arrive at Brook House whose first time it was in custody. This could be quite daunting for them. On the other hand I do not believe the answer should be putting all TSFNOs into a separate wing because this would be placing a label on people. These people have served their time. I also believe that someone with custodial experience could also offer some support to those who had not been in a custodial environment.

Abuse of Detained Persons

318) I cannot recall having any specific concerns about detained persons being verbally or physically abused by staff whilst working at Brook House. However, the majority of concerns were raised through the complaints process, all of which would have had some form of investigation and an outcome. If I had any concerns about this I would have raised this through the appropriate channels.

319) I cannot recall having any specific concerns about detained persons being verbally or physically abused by other detainees. If I had any concerns about this I would have raised this through the appropriate channels.

Detained Person Behaviour

320) I have been referred to document **HOM004130** which is Brook House's Immigration Removal Centre Information and House Rules for Residents. The purpose of this

document is to provide residents with an introduction to the IRC, provide them with helpful information (such as Wi-Fi passwords), and set out our expectations of them during their time in detention and the rules by which all residents must follow. I believe this document is referenced during the induction period and is also available on the intranet for all residents to access.

321) The Inquiry has provided me with documents titled **VER000248**, **CJS000575** and **IMB000043** and asked for my comment. Whilst it is difficult to recall specific details of the support given to members of staff in these circumstances, I am certain that staff would have been given adequate support by their direct line managers. I would be unable to comment any further.

322) In terms of consequences for bad behaviour, the only policy in place to discipline residents' poor behaviour was the use of Rule 40, which could be used to respond to poor behaviour of violent and refractory individuals. However, Rule 40 was rarely adopted.

323) Where we believe a resident has committed a criminal offence, we will report it to the Police. This has always been standard practice within G4S. Primacy of the matter is then passed over to the Police's investigation team to handle accordingly. However, on most occasions, no further action is taken by the Police as the resident is due for deportation in the near future. This, however, is a matter for the Police and Home Office, not G4S.

324) I do believe that G4S' focus should not be around having consequences in place, rather it should be about implementing effective control measures to deter poor behaviour.

325) I have been given access to document **INQ000077**, which is titled Brook House Interview 2 Notes – Steve Skitt (Deputy Director/Head of Brook House) – 17 July 2017. In my personal opinion, I believe it would be beneficial to implement an incentives or privileges scheme whereby residents are awarded for good behaviour. This could be

offering the opportunity to complete paid work, for example. However, I do accept that this would be difficult to implement in practice. Especially in this environment.

326) Paragraphs 82 and 86 of document **VER000264** relate to the Home Office's instruction that "*you must have an Incentive and Earned Privilege policy*". I believe that this policy was stopped, however, I cannot remember the exact date when it was withdrawn. I think it may have been before the Relevant Period. The decision to stop the policy was a direct instruction from the Home Office. I am not sure what prompted this decision within the Home Office. I personally believe that it may have been a recommendation from HMIP, but I cannot be sure of this.

327) In my opinion, IRCs are more challenging than prisons in some ways (contractual and non-operational), yet in the same vein they are also very similar. The similarities predominantly stem from the physical appearance of IRCs and Prisons.

328) From a contractual and non-operational perspective, when I was working in the prison system, the prison itself would have complete autonomy over how you managed the residents. As an example, we had full control over their case management. Whereas in IRCs, our role is to provide a safe, decent and healthy environment and ensure the care and welfare of the individual. The services and care you provide to residents are strictly within the parameters agreed and governed by third parties. As such, the case management of residents at Brook House, including matters of immigration, detention and removal, is dealt with by the Home Office. This detachment from case management oversight sometimes leads to frustration on the resident's behalf as discussed within other parts of this statement. Understandably, residents always want to know the latest information and any updates relating to their case. Again, as previously mentioned, we are in an unfortunate position where we cannot really inform them of anything or help with anything to do with their case because we don't have the answers. The uncertainty surrounding IRCs with regards to deportation and how long they will be in detention for is unlike prison, where there are set sentences, and this uncertainly creates a difficult environment.

329) I have been referred to pages 34 to 35 of document **TRN0000019**, which records me as having told DCO Rachel to "*forget about it*" after she received threats from a detained person. I am unable to recall the context within which this comment was given and therefore cannot comment on whether I agree with the statement that it was "*shocking advice*".

330) The Inquiry has also drawn my attention to a further occurrence involving DCO Rachel where I allegedly pulled her into my office and said that her control and restraint abilities were lacking. Due to the significant time period that has passed since this conversation, I am unable to recall the context behind my actions and what specifically prompted this discussion. However, I am certain that my concern would have been based on advice given by a qualified control and restraint instructor at G4S. I did not have any responsibilities for overseeing the control and restraint abilities of staff. All staff are trained in control and restraint and we are assessed by a qualified control and restraint instructor. It was therefore their responsibility to confirm whether staff members were competent and capable to carry out the work.

331) I have been asked to consider document **CJS000917**, a security meeting note dated 11 May 2017 that refers to an increase in the number of assaults on staff. I would firstly like to confirm that we class an assault from as little as a resident pushing past a staff member, to as serious as someone being punched in the face. There is a very low threshold. I believe that the majority of recorded assaults would occur at the doors to a wing where a resident did not have their ID on hand. In such circumstances, and in accordance with our policies and procedures, staff members do not let the resident through the door and certain residents would barge past staff. These incidents would be recorded as an assault. If there was a resident who repeatedly assaulted staff members you would put them on Rule 40 as disciplinary process.

332) There are formal policies and procedures in place to support staff following an altercation or assault incident with a resident. There is a Care Team at Brook House who were available to support members of staff involved in these incidents. I would also expect line managers to check in with staff members and offer support where

required. However, it is a line manager's responsibility to manage these processes and support systems. I was not directly involved and there cannot comment beyond this.

333) I have been asked to comment on Document **CJS005434** which records a threat against myself and Michelle. I personally am used to having threats made against me. I suppose that it comes with the territory. Nevertheless, I can confirm that I do take all threats of violence very seriously. As soon as a threat has been flagged, a process of gathering evidence related to a threat is triggered in order to validate the alert and inform response and recovery activities.

334) I recall when I received this threat I took immediate action to assess the risks posed and determine whether it was an 'Osman warning'. Named after a high-profile case, *Osman v United Kingdom*, these are warnings of death threat or high risk of murder. In this case, the threat was not classed as an Osman warning.

335) The inquiry have referred me to document **IMB000003**, which makes reference to the Violence Reduction Project. This was a project run by James Begg. I recall that James was given this piece of work to focus on when his secondment came to an end. This project was a multi-disciplinary approach. In so far as I am aware, other interested parties include the healthcare team, the Home Office or other G4S detention centres. I was not directly involved in this project and therefore cannot comment further on the progress of the project or whether the IMB's offer of support was accepted.

336) I have been provided with document **IMB000048**. Page 2 of the document record that a detained person remained continuously on Rule 40 for 15 days. I can confirm that there was not a maximum period for which a detained person can remain on Rule 40 during the Relevant Period. However, it was very uncommon for residents to remain on Rule 40 for in excess of 15 days during the Relevant Period.

Rule 40

337) The Inquiry has asked me to consider documents **CJS001424**, **CJS001448** and **CJS001478** and asked for my comment. These documents relate to a complaint from D87 of gross misconduct and medical negligence while on Rule 40 during a period of continuous watch at Brook House. I note Michelle is specifically referred to as a subject of the complaint as she was involved in the alleged incidents.

338) I understand that the Home Office's PSU complaints and investigation process is continuously observed and monitored. There is no prescribed time limit within which this process should be concluded. The staff members involved in the process also depend on the nature of the allegations made. It is a multidiscipline process.

339) Whether the prior relationship between a detained person and a DCM is relevant to the process depends on the nature and context of the allegations made. This would be considered on a case by case basis. On this occasion, Michelle was acting as Duty Director. It was therefore part of her role to be involved in this process.

340) I do not agree with the statements made within document **VER000242** referring to G4S' mentality towards Rule 40. In my view, there are many reasons why a resident should be put on Rule 40. For example, it would be triggered in response to an incident, assault, or if it is anticipated that a resident will not willingly be escorted to escort providers for transportation. I do not believe that Rule 40 was overused by G4S during the Relevant Period. In so far as I am aware, it was used proportionately in response to incidents that occurred. The G4S Rule 40 paperwork which was completed in association with every period of Rule 40 will evidence this.

Complaints

341) There were many ways in which staff could make a complaint relating to mistreatment of detained persons. Staff could raise complaints verbally to a manager within Brook House. Staff could raise a formal grievance / complaint. They could submit a confidential SIR, or use the Speak Out service.

342) There were many ways in which residents could make a complaint relating to mistreatment of detained persons. Residents could raise a concern verbally to a member of staff or manager. They could raise verbally to a member of the Home Office staff, or raise a formal complaint via the Home Office complaints process. They could report to the IMB, through their solicitors or family, through the Police or through the Gatwick Welfare.

343) Internal investigations would require TOR being issued based on the complaint. These TORs would be given to a manager to conduct an investigation in a recognised format. They would submit their findings and recommendations to the commissioned officer who would decide if any further disciplinary action should be taken.

344) Investigations carried out by the PSU are part of the Home Office and follow their own policies and guidelines.

345) I recall that I was interviewed by PSU on one occasion, however, I cannot recall any specifics other than it relating to a Use of Force where a detainee tried to get out of his room. I cannot recall if it was during or before the Relevant Period. In any event, I never heard anything further from the PSU.

346) I have never been involved in an appeal of the outcome of a complaint to my memory.

347) I wish to say overall that there were processes in place, and being used, to report any poor conduct of staff members by both staff themselves, or detainees. I have to say, the complaints procedure within the IRC is the best I have ever seen in terms of how it investigates and the report that is then put together. This process remains the same today. In a prison, if a prisoner fills in a complaint form it is given to a manager and then the prisoner receives a handwritten answer. Here at Brook House, whenever a complaint is raised through the formal process it is vetted by the Home Office as to whether PSU or G4S should investigate the complaint locally. ~~it is fully investigated..~~ When the Home Office nominates G4S to review the complaint, the local complaints team writes to a manager to ask them to comment or provide a response to the complaint

they respond with a full letter. Staff will be asked to submit their notes around meetings with residents and any CCTV footage will be reviewed if relevant. A letter is provided to the detainee confirming the outcome of their complaint. I believe the process is very thorough.

348) Generally, on a day to day basis, complaints would only filter their way up to myself as Deputy Director if it had been upheld, partially upheld or if the complaints team felt that it needed oversight from myself On these occasions the responses to the complaints would come to me for sign off, however, there was a specific complaints department who dealt with the investigatory process of these complaints. Detainees raising complaints would put the completed form into a locked box on the wing. This locked box was only able to be opened by Home Office staff. Karen Goulder was the person I knew who dealt with the complaints and she would disseminate them to the functional heads if the complaint was related to that area. Karen would log the responses once the investigation had been done and, if upheld, that is when it would come to myself for final sign off in my opinion Karen had a very robust process in place.

349) The process as described above, is a recognised approach to investigations.

350) I would always encourage staff members to report anything if they have seen something they think to be inappropriate. They could report it using the channels mentioned above, raise it directly with me or through Speak Out. If I get hints of anything within a meeting that something has happened I would almost get on my soap box and say that everyone has a duty of care here to report any wrongdoings. It is my personal view that if people don't report seeing bad behaviour they're almost acting as badly as the person who's done the thing wrong in the first place. I have dealt with cases where people have ended up on the other side of the door during my time in prison so I'm extremely rigid on this.

351) The Inquiry have referred me once again to document **INN000007,** the Rule 9 witness statement of Owen. Having reviewed the specific paragraphs of his statement requested of me, I could not comment on the events in paragraph 125 as I was not at Brook House at the time. As for paragraph 162, as far as I'm concerned, reports were and are being

made through the correct channels always during my time at Brook House and therefore I never had any reason to believe that it was a system that was not working. I have worked in places before where this type of reporting never happened but here the level of SIRs raised were quite healthy. Any incident reported should be looked into in my opinion.

352) Any complaint regarding Healthcare would have been forwarded to the Home Office for them to deal with and allocate to the Healthcare provider. Residents could also complain directly to the NHS, following the NHS complaints procedures.

353) All whistleblowing reports would go through to the top and undergo a high level of scrutiny before anyone at the centre would be notified of them to undertake any follow up action. Some reports may not even go to the centre. Some of them would just go to the Director.

354) As far as I am aware, the whistleblowing policy and procedure at Brook House was well thought out, fit for purpose and did its job at the time.

355) I have reviewed document **CJS000512** which is the G4S Gatwick IRC Anti bullying Policy dated 22 June 2016. As far as I am aware it was fit for purpose and did its job at the time. The policy has evolved over the years and continues to evolve, depending on the issues we witness in the IRC. Staff are made aware of this policy during their ITC.

356) The Inquiry have provided me with a number of documents that reference a number of complaints that were raised during the Relevant Period. I have been asked to comment on my involvement with these complaints. I will take each one of these in turn.

357) Document **CJS001397** this document refers to allegations of human rights abuses in Brook House. My involvement involved considering the investigation report relating to the complaint and speaking to the clinical leads in order to form a decision on the appropriate action to be taken. I then drafted the letter in response to the complainant addressing each aspect of the complaint in turn.

358) **CJS001572** and **HOM002695**: these documents relate to an unfair treatment Complaint made by D740. I recall that I followed a similar process as outlined above when responding to the complaint submitted by D740.

359) Document **CJS001575** relates to the investigation into D544's complaint in April 2017. I seem to recall there was an influx of resident complaints relating to the physical environment once additional beds were introduced at Brook House. I do not recall what I did specifically as part of this investigation, however, I assume that I would have gathered information by interviewing the complainant, officers and departments involved. I would have collated all of my findings and evidence into an investigation report.

360) **HOM003107**, **HOM002361** and **CJS001478** refer to an investigation into allegations made by D87 against Michelle. I conducted this investigation by myself as Investigating Officer. Following my investigation, I would have prepared a letter of response outlining the action taken to investigate the allegations, the evidence reviewed and my formal decision taken in respect of the complaint. My investigation found his allegations to be unsubstantiated. In this case, I believe that the resident took his frustrations out on Michelle because she was the Duty Director.

361) As per document **HOM002354**, it is correct that I was interviewed by PSU in respect of their investigation into complaints made by D87 about unwarranted Use of Force. I recall that I provided PSU with all the information that I held at that time in relation to the matter and complied with every aspect of their investigation.

362) I have considered documents **CJS001400** and **CJS001443** in relation to the allegations against Darren Tomsett. It looks like I initially asked for Conway Edwards to look into this complaint and his outcome was unsubstantiated. I note from the email trail that Dan Haughton carried out a quality assurance check but I cannot recall any further part I played with this matter.

363) **CJS001625** records a complaint submitted by resident D283. I cannot recall any specific details relating to this matter. I can see from the formal letter of response that Caz Dance-Jones dealt with this particular complaint. Because particular elements of the complaint were upheld, I would have been notified of these as Deputy Director. I expect that Michelle would have issued further guidance to relevant staff members on breast feeding following this complaint.

364) Documents **CJS001534** and **HOM002703** relate to allegations of sexual harassment and assault made by D732 on 31 July 2017. As this complaint involved an allegation of a criminal offence, I remember that we handed this matter over to the Police to formally investigate. Following this referral, I would have had no further involvement in this matter.

365) Document **CJS001566** refers to a complaint dated 23 May 2017. Due to the passage of time, I do not remember the details of this complaint. I understand that James Begg conducted the investigation. Based on my limited memory of this matter, I believe that my email provided at page 15 of document **CJS001566** is referring to the fact that James Begg will need to interview me as part of his role as Investigating Officer of the complaint in order to understand my version of events.

366) It is correct that the changes made around the welfare provisions are the changes referred to at page 10 of document **CJS001566**.

367) I believe that the role of Welfare Officer in both Brook House and Tinsley House is very important. They offer a great deal of support and guidance to residents on a wide range of matters and are a great point of reference. They manage Legal Aid, for example.

368) **CJS001483** details a complaint made by D642 in respect of property damage and the use of homophobic language. As this complaint contained allegations of unwarranted Use of Force, this matter was referred to the PSU to be subject to their investigation. I therefore had no involvement in this matter.

369) I have reviewed to document **CJS001578**. Disciplinary action was taken against DCO Lunn or DCO Albert. This involved a formal meeting with both DCOs to confirm that this type of behaviour is not acceptable and will not be tolerated. We would have reiterated the importance of them respecting residents' property. No formal warnings were issued.

370) I have once more considered Owen's statement to the Inquiry at paragraph 167 of document **INN000007**. The mandated staffing levels for Brook House will have been agreed in the Gatwick IRC contract negotiated with the Home Office. The subsequent increase in Welfare Officers would have been a joint decision between G4S and the Home Office following consultation. The contract would have been varied accordingly.

371) With reference to Michelle's conclusion at page 7 of document **CJS0073663**, I do not recall Michelle raising this matter in an SMT meeting. Without sight of the minutes of this SMT meeting, I am unable to comment upon what specifically took place.

372) The Inquiry has noted documents which show that I authorised payment of compensation to residents for loss of property or replacement of property. If, following a formal investigation, complaints in relation to property damage or loss of property are found to be substantiated, G4S will offer the complainant compensation. The monetary value of the compensation offered depends on the value of the property in question and this would be decided on a case by case basis. If the resident accepts our offer of compensation, the Finance Department will ensure the money is sent to the residents' account.

The Panorama Programme

373) I can confirm that I knew of Callum Tulley, and would see him on occasion around the centre and in morning briefing meetings. I remember that I was once investigating a staff member for potentially making a pass to a detainee and Callum was a witness to

this, however, Callum would not let me take a statement from him for the purpose of the investigation.

374) As above, I knew Callum Tulley from seeing him around the centre. When he started working at Brook House he was one of those employees who was quiet and shied away from his role. His behaviour completely changed during the Relevant Period and all of a sudden he wanted to be involved with things. In hindsight, now I know why this was.

375) Directly after Panorama aired there was definitely a visible lull with staff. It definitely had an impact on them and they seemed quite numb for a few days. People were angry with what had happened and trying to bring all these emotions in from people is difficult. I was fully expecting a mass exodus of staff after Panorama aired, but this did not happen. The majority of staff understood what the programme showed and understood what their roles would be in making sure that Brook House was not viewed in this light moving forwards. We did a lot of work with staff and spoke to them about the implications of the documentary. A lot of staff accepted where we were, what needed to be done and therefore stayed to make sure changes happened.

376) The airing on Panorama did not have as much as an impact on the detainees as we expected. We expected a really hard time and so the morning after Panorama aired we had additional staff on duty, and others on standby. Some detainees voiced their opinions but from what I recall there was no violence against staff members.

377) I was Deputy Director of Brook House when Panorama aired and it was a very difficult period to go through. I went to the G4S Director who came down as part of the investigation team. At that point we had no idea what was going to be implicated or who was going to be implicated. I remember that the SMT were called into Ben's office maybe a day or so before the programme was due to be aired and this was the first time I became aware of the Panorama broadcast. I remember watching the documentary when it aired with the G4S Director. They wanted me to watch it with them so I could identify staff. In my 30 years of working in this industry it was one of the most shocking things I've ever seen. I have seen things over the years and reported staff myself in

previous roles for assaulting people within the prison environment but I've never seen anything like what was shown on the Panorama programme. I was not aware of any of the incidents of mistreatment shown on the Panorama programme. Had they have been raised with us the incidents would have been looked into appropriately.

378) People will always be more guarded around someone who is in a more senior role or my role. From a personal view, I cannot recall anyone that had said something like that in my presence. I have dealt with the aftermath of things that have been reported and investigated as I would be involved in the disciplinary processes that followed.

Specific Individuals

379) The Inquiry has asked me to provide comment on specific individuals. Please see my comments below in relation to specific individuals as I knew them before Panorama aired:

- Nathan Ring: I recall working with Nathan Ring on occasion. I do not recall ever witnessing Nathan Ring use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse until I watched Panorama.

- Steve Webb: I recall working with Steve Webb on occasion. I had no concerns about his views/behaviours. I do not recall ever witnessing Steve Webb use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Chris Donnelly: I know Chris Donnelly and he continues to work at Brook House at present. I had no concerns about his views/behaviours. I do not recall ever witnessing Chris Donnelly use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Kalvin Sanders: I recall Kalvin Sanders being a staff member at Brook House. My personal thoughts were that he liked to 'big himself up' but pre-Panorama I had no concerns about his views/behaviours. I do not recall ever witnessing Kalvin Sanders use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Derek Murphy: I recall that Derek Murphy Was a DCO. Derek was one of those people who thought he knew everything but I had no concerns about his views/behaviours. I do not recall ever witnessing Derek Murphy use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- John Connolly: I remember that John Connelly as a DCO and Use of Force instructor and coordinator. Pre-panorama I had no concerns about his views/behaviours and I do not recall ever witnessing John Connolly use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Dave Webb: I knew Dave well as a DCO and Use of Force instructor. During the Relevant Period I had no concerns about his views/behaviours. I do not recall ever witnessing Dave Webb use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse, however, I do recall that there was an investigation into his behaviour on one occasion when teaching the Use of Force course at another prison. I note that details of this are contained within documents **HOM001120** and **HOM001446**. I did not witness this behaviour myself but I understand it revolved around making inappropriate comments. I wrote to David Webb suspending him from duty in February 2018 following these allegations.

- Clayton Fraser: I recall Clayton being a DCO at Gatwick IRC, but I think he worked at Tinsley House. I had no concerns about his views/behaviours. I do not recall ever witnessing Clayton Fraser use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Charles Frances: I recall that Charles was a DCO and remember him being a nice guy. I had no concerns about his views/behaviours. I do not recall ever witnessing Charles Frances use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse. When Panorama came out I was shocked to see him on there.

- Aaron Stokes: I recall Aaron being a DCO. I had no concerns about his views/behaviours. I do not recall ever witnessing Aaron Stokes use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.
- Mark Earl: I recall Mark being a DCO. I had no concerns about his views/behaviours. I do not recall ever witnessing Mark Earl use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Slim Bassoud: I know Slim and he still works at Brook House as a DCO. He is a nice guy. I had no concerns about his views/behaviours. I do not recall ever witnessing Slim Bassoud use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Sean Sayers: I did not know Sean Sayers well but I know he was a DCO. I had no concerns about his views/behaviours. I do not recall ever witnessing Sean Sayers use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Daniel Small: I recognise this name but cannot put a face to him and so cannot provide any further comment on this individual.

- Yan Paschali: Yan was a DCM. I had no concerns about his views/behaviours before I watched Panorama. I do not recall ever witnessing Yan Paschali use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Daniel Lake: This name sounds familiar but I cannot put a face to him and so cannot provide any further comment on this individual.

- Babtatunde Fagbo: I remember Babtatunde was a staff member at Brook House. Babs would sometimes get into verbal confrontations with detainees and I remember that this led to disciplinary action. I had no real concerns about his views/behaviours other than those he was disciplined for. I do not recall ever witnessing Babtatunde Fagbo use derogatory, offensive or insensitive remarks myself and did not witness any incidents of verbal or physical abuse myself.

- Shane Munro/Monroe: I recall Shane being a staff member at Brook House. I had no concerns about her views/behaviours other than time keeping and attendance concerns. I do not recall ever witnessing Shane Munroe use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

- Nurse Jo Buss: I know that Jo Buss was promoted within the healthcare team not long before either the Relevant Period, or not long before Panorama. I am unsure whether she was a mental health nurse or a general nurse but I had no concerns about her views/behaviours. I do not recall ever witnessing Jo Buss use derogatory, offensive or insensitive remarks and did not witness any incidents of verbal or physical abuse.

380) In addition to the above, I have also been asked specific questions in respect of the following individuals.

Neil Davies

381) When I started my secondment at Brook House in the position of Head of Security, I was told by Ben that they had interviewed for the Head of Security job and selected someone called Neil Davies (**'Neil'**). I provided Neil with general guidance on the process is on the department and assisted him with corruption training. I cannot remember specific examples, but the purpose was to guide him, help him learn the

process and make sure that he took the time and embed himself into the role. My view of Neil was that he talked a good game, but he did not have the experience or competence to back it up. Neil told you what you wanted to hear and, unfortunately, I did not see through this at the time.

382) I discussed Neil with Kate Lampard which can be found in **VER000248**. As this document is a transcript I believe it must be an accurate record of my comments. In my interview with Kate Lampard I stated that "*the deeper I delved the more I realised that Neil had blagged it*" [**VER000248**, paragraph 88]. I am sure that I would have spoken to Ben about this. We would often take time over a cup of tea and talk to each other about what was going on in the centre and our thoughts.

383) Neil, as Head of Security, reported to me because, as Deputy Director, I sat above him in the management structure. This was the accepted line management structure across all of the IRCs and prisons.

384) At paragraph 88 of **VER000248** I a recorded to have said "*then there were a number of other issues about other members of the SMT getting involved, and at the time Stacie was quite vocal*". Here I would be referring to the fact that Stacie was vocal about the fact that Neil was not particularly good at his job.

385) I have reviewed paragraphs 41 and 94 of document **INN000007** as requested by the Inquiry. This document contains the witness statement of Owen, former Welfare Officer at Brook House.

386) There were a number of concerns raised about Neil and how he spoke to people. I believe that his personality clashed with a few other individuals also. The decision was taken to suspend Neil while an investigation into these complaints took place. This was because it was clear from the number of complaints received that the issues were a lot more deep rooted than we initially thought. I do not recall having any involvement with the complaints or grievances against Neil. Neil resigned during his suspension.

387) I did not observe any inappropriate behaviour from Neil towards any detained person or member of staff. If I had observed such behaviour I would have reported my observations through the correct channels. As discussed in my interview with Kate Lampard, I was shocked to hear of the allegations but also shocked at myself because I did not understand how I could have missed it [**VER000248,** paragraphs 128-129]. Members of staff seemed to believe that I was supporting Neil when this was not the case at all. It seems that it was Neil who was giving this impression to people and because of this I feel that people were hesitant to speak to me about their concerns regarding Neil.

Caz Dance-Jones

388) After Neil's departure Caz Dance-Jones became Security Manager. I can therefore confirm that I agree with this part of Dan's comments in document **VER000277** at paragraph 156.

389) By way of background, after Neil resigned and Sarah moved to Tinsley House, this left Stacie without a job. Stacie was the right grade to move to the Head of Security role at Brook House, however, Stacie went on sick and subsequently resigned. In the interim gap, we decided to interview for a temporary Security Manager. This role was created to just look after security and the role did not involve any of the other elements or responsibilities of a 'Head of Security' role. We advertised the temporary position and Caz got the job. Caz was interim Security Manager at Brook House, not Head of Security. When Caz was appointed we did not have a Head of Security.

390) I feel that I had a good working relationship with Caz. I thought that she really knew her stuff. Sometimes Caz could be a bit unsure of herself, but I had an agreement with Caz that I would always be on call for her if there was anything she needed advice on. I think that some other staff members saw Caz to be a vindictive character.

Michelle Brown

391) Not long after Caz was appointed as Security Manager, I met with Michelle, as her line manager, and told her that she needed to look at how she could develop herself and what other roles might be suitable. When the vacancy came up for the Head of Security role, Michelle wanted to go for it. Michelle was successful in her application and was appointed as Head of Security on 1 June 2017. After this we then moved to recruit for a new Head of Safeguarding (Michelle's previous role).

392) I assisted Michelle in her new role as Head of Security during 2017 and I believe that Michelle took full control of the role in 2018.

393) I believe that I had a fine working relationship with Michelle, however, she was very full of her own self-importance and a bit of a narcissist. You could tell this from the way she spoke about herself. She was quite a flamboyant personality.

Dave Killick

394) Dave Killick (**'Dave'**) was a control and restraint instructor in Brook House. Dave was one of the individuals who raised a grievance against me. I have reviewed documents **CJS0073051**, **CJS0073047**, **CJS0073334** and **CJS0073109** which have been provided to me by the Inquiry and they all relate to Dave's grievance. It can be seen from these documents that Dave raised a large number of allegations against me. These were: bullying staff, taking bribes, breaking company policy, breaking company guidelines, intimidating witnesses, ignoring CCTV evidence, discussing grievances in staff briefings, ignoring complaints and not allowing staff the right tell their side of the story. I denied each and every one of these allegations.

395) The background to these allegations was that Dave attended a course thinking he was booked on one when he was not. I had cancelled the booking in line with the previous stance taken by the company. Dave had been suspended so was not allowed to attend a previous course. I was not aware that discussions had been held with Lee in which Dave

had been told he could go on this course. I instructed another staff member to cancel the course and tell Dave. Unfortunately, this person did not inform Dave.

396) From my perspective, the grievance raised by Dave did not have any impact on my relationship with him as a colleague. I continued to work with him as normal. I was transparent in all the investigations because I had nothing to hide.

397) I have been asked to comment on paragraph 335 of document **VER000223**, within which Sarah states I was in the room when she had a call with Ben in respect of Dave attending the training and that I did not mention anything about the booking being cancelled. I do not recall being present for this conversation. If I had been there and knew what they were talking about I would have said something. If I was present in the room I can only assume that I did not hear it or I did not make the connection that they were talking about Dave attending the course. I had nothing to gain by allowing Dave to attend a course I knew he was no longer booked in for.

David Waldock

398) David Waldock (**'David'**) was a DCO at Brook House. David was another of the individuals who raised a grievance against me.

399) I always felt that I had a good working relationship with David. He was a bit of an odd character but I had no concerns regarding his work and always dealt with him well in a professional manner.

400) I have reviewed documents **CJS0073634**, **CJS0073274** and **VER000219** which have been provided to me by the Inquiry. These documents all relate to David's grievance. I am unable to recall the exact allegations in detail from memory, and so can only go off what is contained within documents **CJS0073634** and **CJS0073274,** however, I was confident that the allegations were baseless and I was happy for an investigation to take place because, similar to the above, I had absolutely nothing to hide.

401) From my perspective, the grievance raised by David did not have any impact on my relationship with him as a colleague. I would not let it. I continued to work with him in a professional manner.

402) I have been provided with document **VER000061** by the Inquiry. This document is a letter from David to Ashley Almanza dated 15 April 2017. I can confirm that I am aware of this letter. I cannot recall the exact date, but as soon as the letter was received in the office I was made aware of its existence. I do not think I ever actually had sight of the letter and this is the first time I have seen it in full.

403) When I was initially told about the letter, I was told that Steven Cotter (Head of Insurance and Risk in G4S at the time) was going to be carrying out an external investigation.

404) When I was given a summary of the contents of the letter during the investigation I was disappointed because I thought David and I had a good working relationship and I was shocked that he would make such allegations against me which were untrue. Unfortunately, these sorts of things do come with the job role I had. I can only gauge that people had issues around my management of them.

405) I have been asked to provide details of a meeting with David on 2 February 2017, referred to by David within document **VER000061**. During that time I would have had a number of meetings and I cannot remember this one specifically as it was five years ago.

406) I have reviewed document **CJS00073634** and note that David reported to the Speak Out helpline that I told him "if you make any more trouble you will be terminated". This is not something that I recall saying and it is not something I would ever say to staff members. Most organisations have a 'Speak Out' helpline. They are very valuable and give staff an opportunity to say something when they want to remain anonymous. It is a valuable tool which allows people to raise a concern, especially when it is about

management. The Speak Out process is completely independent from the organisation. It is an independent review tool.

407) Within document **CJS00073634,** there is comment that the handling of the complaint from the Home Office was clumsy. I agree that the investigation should have been dealt with quicker, but my involvement in this process was very limited. I only had a meeting to respond to the allegations and that is all. In hindsight, yes, it could have been handled better.

408) I have been asked to provide my view on the comment within document **CJS00073634** which reads *"[T]he findings of this investigation do, however, give credence to many of the concerns that David Waldock articulated about Guyatri Mehraa."* Guyatri was a strong character and had been there for some time. However, in hindsight, yes, I think she could have been managed better. It could have been handled by her direct line manager, or line manager's manager. I would not be expected to get involved with her management or grievances raised. It would be the responsibility of the manager below me to handle. But at the time, I thought Guyatri was doing her job fine.

409) I disagree with the comment within document **CJS00073634** that says *"... Guyatri has indeed, to a degree, been protected by Management"*. She was not being protected by management to my knowledge and she certainly was not being protected by me.

410) I was aware of the letter which had been provided as document **CJS0073243**. The only comments I wish to add in relation to this grievance outcome is that I used to attend the morning briefing every day. I asked Juls to stay behind and I was making a comment about one of the wings that was not very clean. I absolutely was not saying 'homosexuals are disgusting' as was alleged by David.

Stacie Dean

411) I have already detailed Stacie's role at Brook House within paragraphs 21) and 389) of this statement. I have been referred to documents **CJS0073632** and **CJS0073633** which

are documents relating to a grievance made by Stacie. Due to the period of time that has passed since this was raised, it is difficult for me to recall any specific allegations made against me personally, and I can therefore only go from the documents themselves. The concerns raised in the documents appear to be general allegations about a number of individuals, mainly Ben. I do recall that Stacie raised an issue but I cannot recall any conversations. I know that I dealt with a few bits around Luke Instone-Brewer and Babtatunde Fagbo and I remember that I dismissed Luke Instone-Brewer for inappropriate comments but other than this I am struggling to recall the specific issues referred to.

412) From my perspective, I thought I had a fairly good working relationship with Stacie. As far as I am aware, the grievance raised by Stacie had no impact whatsoever on this relationship.

Adel Hinder

413) I have been provided with documents **CJS0073398**; **CJS0072898** and **CJS0073174** which relate to a grievance raised against me by Adel Hinder ('Adel'). Adel alleged that I said "I don't like lesbians anyway". This grievance was raised towards the end of 2018 and so it did not take place during, or near to, the Relevant Period. I recall this grievance as I was suspended while the grievance was investigated. I categorically deny saying that I don't like lesbians. I do not know where this came from. I would never say anything like this and it is not in line with my views.

414) In terms of the grievance process, I was called into Phil Wragg's (**'Phil'**) office (the Director at the time). I was told there was an allegation raised against me and that Sarah had been asked to carry out an investigation. I was informed that Sarah had fed her findings from her initial investigation back to Phil and I was subsequently suspended on full pay pending a formal investigation. I never saw Sarah's investigation report. My suspension began around two weeks before Christmas. I was told that I was suspended for behaviour, but this then changed to language. I was not actually told what I had been alleged to have said or done until an interview in January 2019.

415) I appealed the decision for suspension. I understood that people had said things but I did not understand why I could not go and work somewhere else while the investigation was carried out. While this investigation took place I was placed on paid suspension and this lasted for around six weeks.

416) I cooperated fully throughout the investigation and made myself available throughout my suspension to assist with the investigation if required. I could not attend the initial interview date as there was an issue around me getting my association officer to attend my interview with me. I didn't want the interview to go ahead without a representative present. Then the investigating officer wasn't free until the end of January to hold the interview. Gazette Saunders was the investigating officer. My one and only interview was held at the end of January and lasted for around 30 minutes.

417) Following the investigation, Phil called me up and confirmed that I could come back to work. When the investigation finished all I was told was that 'the investigation has finished' and was told 'your chair is warmed and you can come back to work'. I also got a letter from the Home Office reinstating my Home Office accreditation which had been overturned pending the outcome of the investigation.

Chris Malden

418) I have been provided with document **CJS0073216** which contains grievance hearing notes of Chris Malden (**'Chris'**). Again, this falls outside of the Relevant Period. Chris raised concerns that he thought I was preventing him progressing within the company. This was not true.

419) I would not say I was 'friends' with Chris for the sole reason that I would not consider myself to have any 'friends' within the working environment, I never have done as I like to keep work very separate. It came to light that Chris worked the doors on nights out as a second job. He put in a request for second employment. In most custodial environments, working the doors and financial services are the two roles that you were

not allowed to pursue as secondary employment because it can be a conflict of interest. I therefore told him that he should not work the doors. This is standard procedure for working at the IRC and prisons.

420) At one point, it was company practice for staff members who were two grades below me to conduct the interviews for DCM applicants. If the interviews were conducted by Michele Brown and Michelle Fernandez, as mentioned by Chris in **CJS0073216**, then this was before I was even holding interviews. So I definitely know that I was never involved with Chris' interviews. In my view, I never prevented him from progressing.

Contractual Penalty Points

421) Functional heads would have their own KPIs. I would attend a Weekly Operations Review Meeting (**'WORM'**) with Paul. This WORM meeting may have been called something different during the Relevant Period. We also have a monthly contract review meeting and a quarterly review meeting with the Home Office. I attend these meetings to provide information to the Home Office.

422) In terms of how Brook House managed the issue of penalty points, I would discuss these with Paul, where he would highlight the penalty points for failures. We would then go away and look at it and the following week we would respond to the Home Office with any mitigation. If we did not have any mitigation then we would have to accept the penalty points. Document **CJS004584** provides an example of this.

423) All staff knew what was expected of them in terms of contract compliance, and they were aware that there were KPIs within the contract.

424) Document **CJS001560,** contains an email from me at page 7 approving a draft letter to detained person in respect of a complaint for the late receipt of a fax/bail summary for a bail hearing the following day. It was found that the bail summary had been sent to the wrong fax address and was not sent to Brook House. It therefore was not our issue,

it was the Home Office who sent it to the wrong address. As such, no further action was required on our behalf.

425) It would be very difficult to provide a view on how often Brook House was successful in challenging the penalty points under the contract with the Home Office during the Relevant Period. I could not put a figure on it. Some we were successful, some were not. Paul was very reasonable.

426) I note that Karen Goulder mentions a 'mitigation table' within documents **CJS001622** and **CJS001522.** If a complaint submitted by a resident was upheld it would be classed as a failure and go onto the mitigation table to be discussed with the Home Office regarding our failures for that week.

Lessons Learned / Post Panorama

427) Lessons were learned from the very top of G4S to the bottom following the broadcast of Panorama.

428) Management were frustrated that we didn't see the issues. Following the broadcast, there were action plans drawn up over a period of time. We addressed the issues that were highlighted by the programme. From then until now, it has been a continuous path of learning and adapting. What we saw on that programme was horrendous. As mentioned previously within my statement, we were very shocked for quite a few days following the broadcast of Panorama.

429) I do not believe that the events shown in Panorama at Brook House were foreseeable in light of the Medway report. The Medway Report cascaded down to centres as to what is good practice but it is slightly different to what we have at Brook House as the Medway Report centred on a children's centre.

430) I have noted the comments of Owen within document **INN000007** in which he says Ben warned something like Panorama would happen. I was not aware that any such

statement had been made by Ben and I cannot recall having any similar conversations with him.

431) Within document **IMB000026,** at Item 4, I discuss a number of points which have been actioned or were in place at Brook House prior to Panorama. I mentioned that, prior to the programme airing, pre-emptive work had taken place within the centre to ensure that there were no issues within Brook House. Staff and detainees had also been spoken to and letters distributed. Here, when I refer to 'issues' I am referring to disgruntled residents and staff. I cannot recall when precisely staff and detainees were spoken to. The letters I refer to were those sent to staff members to notify them of the Panorama programme. We tried to communicate this as quickly as possible to all staff members.

432) I have reviewed page 10 of document **HOM002484.** Within this document it is recorded that I asked that the PSU delay issuing interview requests to Derek Murphy and Sean Sayers regarding D1234's complaint until after the airing of Panorama. I cannot remember why I delayed these requests. I may have been asked to do this by Ben. Maybe we knew the Panorama programme was airing and we wanted to get that out of the way first. I clearly had a conversation, I'm not denying that, but I cannot specifically recall why.

433) After Panorama aired disciplinary action was taken against certain staff members shown in the programme. The staff members were initially given final written warnings. We were then told by the Home Office to revoke the accreditations of these staff members. At this point they physically could not carry out the work at Brook House because they were not accredited.

434) Documents **CJS0072868**, **CJS0073082** and **CJS0073152** show that I was responsible for dismissing Stephen Webb, Sean Sayers and Derek Murphy after the Home Office had decided to revoke their certification. These individuals had initially been giving a final written warning by G4S as mentioned above.

435) I have been asked to provide my view on the correctness of the initial decision to hand out final written warnings, however, I was not party to the investigation and therefore am not well placed to comment on the correctness of the decision. This goes for all individuals.

436) I didn't have many discussions with the Home Office about the decision to dismiss the above individuals. It was quite clear that nothing could be done once they made their decision to revoke the accreditation. There was nothing I could do.

437) Following Panorama, an action plan was formulated and drawn up between G4S and the Home Office. It was directed from high level individuals within G4S. Some work had been done on it by Peter Needham. Once an initial draft had been put together, we were all invited up to London where the action plan was set out to us all in a formal meeting. The individuals involved in putting together the action plan included Peter Needham, Jerry, Ben, G4S top legal guy and the Home Office.

438) Document **CJS000736**, which is a Brook House three month action plan dated 15 September 2017. The Home Office agreed to this plan. I can confirm that I completed all tasks which were assigned to me. I think they were also done by the set deadline. The fact that my action points are marked green indicates that they were all done.

439) Document **NSH000019** at page 1, records "*All going well. Good improvement since the panorama with a formal action plan in place".* After Panorama aired there was a manic period of improvement. Ben was also removed from his position as Director so I was left on my own. It's hard to pinpoint specific improvements during that six week period. I briefly recall that we did do forums on the wings, reviewed staffing levels across the site, and we set out plans going forward.

440) Document **HOM0331995**, records that the focus of Brook House post- Panorama was to deal with the drug issues. This action plan was implemented. Without the figures to hand, I think it may have provided a reduction in the number of drug related incidents

at Brook House. I feel that the action plan also gave people a steer and got more people on board to try and tackle the problem.

Verita Investigation / Further comments

441) I have been asked some further specific questions about my first interview with Kate Lampard [document **VER000248].** I can confirm that at paragraph 157 of this interview I am referring to Yan Paschali. Yan would come across as a pretty okay character. I had no reason to suspect that he was conducting himself in the manner shown on Panorama. It would therefore be difficult for me to say why no one reported any conduct from him as shown on Panorama. I do not know why people did not report it if they witnessed it. I certainly did not witness it and do not recall any behaviour such as that relating to Yan being reported to me. I myself had never seen it but if I did I would have made sure it was raised through the correct channels and investigated.

442) I have been asked to provide any comments I have on the certain notes recorded during the Verita investigation relating to myself. My comments are as follows:

- **VER000291** at page 98: *"Think lacking in sight. Solipsistic, self-satisfied...Weak. Unable to judge character. Obvs not respected by staff who didn't confide in him about Neil"*. I think that the Neil being referred to here is Neil Davies. He was suspended and resigned because there were complaints that he had been bullying staff. In response to this, I would say that this seems to be their opinion/observation but I would disagree with it entirely.

- **VER000292** at page 98: Kate Lampard's Observations on E wing: *"Dan Houghton + Steve Skitt - low key + lazy. Hanging about"*. My comments in relation to this would be that part of my role is to walk around and monitor what is happening and talk to residents and staff members on E wing. I don't actually work *on* E wing. It is also not my job to be liked. These notes seem to have arisen from the comments of other people but I do not believe them to be substantiated.

I feel as if these comments are not reflective of the truth or are an accurate representation of me. I have reviewed my previous 360 1-2-1s and performance reviews and issues or concerns of this nature have never been raised previously. In fact, I have been in this job for 36 years and not one person has ever mentioned those traits to me. I feel as if it is a damageing statement. I am quite offended by the comments and disagree with them. As such, as far as I am concerned, what has been written here is not true.

443) I have been asked by the Inquiry to comment on paragraph 168 of Callum Tulley's statement to the Inquiry at document **INQ000052**. Having reviewed these comments, I personally do not believe that is the case. I don't think an entire team would miss something like that. I also note that at paragraph 169 of Callum Tulley's statement to the Inquiry, he describes "*cultural, systematic failings*". I would not agree with this comment.

Suggestions for Improvements

444) I have no further suggestions for improvement.

Any Other Concerns

445) I have no further matters to add which relate to the culture of G4S at Brook House or the treatment of individuals detained at Brook House.

446) I know of no other person/ persons who have worked or are working at Brook House that I believe are knowledgeable about the matters I have mentioned in my statement that have not been asked to provide a statement of their own.

447) I do not know of any further matters which I consider relevant to the Inquiry.

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	Stephen Skitt
Signature	**Signature**
Date	04.03.2022