BROOK HOUSE INQUIRY

First Witness Statement of Sarah Newland

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 21 February 2022.

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.

I, **Sarah Newland**, will say as follows:

Introduction

1. My full name is Sarah Newland and my date of birth is DPA

2. I graduated from the University of London in 2000 with a degree in French and Management.

3. In 2004, I joined Colnbrook Immigration Removal Centre as a Custody Manager. Colnbrook was run by Premier Custodial Group at the time (later Serco), but is now run by Mitie.

4. I joined G4S in December 2007 as an Operations Manager on the Overseas Escorting contract. This was predominantly an office based role, where I managed

over 200 overseas escorts, repatriating detainees on scheduled and charter flights. Responsibilities included contractual delivery, staff rostering, employee relations, detainee complaints and on call duties. I did not wish to be part of the TUPE transfer when this contract transferred to Reliance Secure Task Management in 2011. Therefore, I remained with G4S to work on a new initiative, Cedars.

5. Cedars was a pre-departure accommodation ("**PDA**") centre which housed children and families. It formed part of a new initiative to end the detention of children and was run in collaboration with Barnardo's. The centre was located in Pease Pottage. I became the Head of Cedars PDA in May 2011 and remained in this role until it closed in October 2016. My role predominantly consisted of contract management duties to safeguard vulnerable families with children, ahead of their removal from the UK.

6. In October 2016, I took up a post as the wider Head of Tinsley House, Borders and the PDA. I remained in this role until July 2019, so I was in this role during the Relevant Period. I had responsibility for the Tinsley House contract, including the immigration removal centre ("**IRC**"), the PDA and the separate Borders suite for individuals who are denied entry to the UK and are then returned to their country of origin. I was the most senior manager at Tinsley during this period. My role was largely focused on strategic overview – how to improve the service, initiatives to improve the environment and life for detainees, engagement with the Home Office and contract meetings. I had day to day management responsibility for Tinsley House and the PDA, but I also undertook Duty Director ("**DD**") responsibilities at Brook House from time to time.

7. I became the Deputy Director of Gatwick IRCs and PDA in July 2019. This is my present role. I TUPE transferred from G4S to Serco when the contract changed in May 2020. In this role I have operational oversight and management of Brook

House, Tinsley House and Gatwick PDA, ensuring high standards of care and service delivery. The role includes senior on call duties.

8. I have been asked to comment on the management structure at Brook House, but I did not work there during the Relevant Period. I was the Head of Tinsley House, reporting to Ben Saunders and later, Lee Hanford. I only worked at Brook House in the role of DD, or when I visited Brook House for Senior Management Team ("**SMT**") meetings that took place once a month.

9. When Tinsley House closed for refurbishment, my base of operations did not transfer to Brook House (as was the case for many officers), as I was still involved in many aspects relating to Tinsley House. This included the refurbishment work, meetings with the Home Office and planning surrounding the reopening. Therefore, my knowledge of day to day life and operations at Brook House during the Relevant Period is limited.

10. I have considered document CJS000495. I attended SMT meetings during my role as Head of Tinsley House. The meetings usually took place monthly and provided me with an opportunity to update the wider SMT on issues relating to Tinsley House, which was my main area of focus and responsibility. Therefore, whilst the Inquiry has referred me to discussions / comments made during SMT meetings, many of these points would have centred on Brook House as it is the larger and more highly populated of the two centres. Therefore, it is unlikely that such issues would have been directly relevant to me or my role at the time.

11. With regard to document CJS000495, although I see reference to a proposed organisational structure, there is insufficient information for me to recall the detail of this.

Appointment to Head of Cedars

12. I have reviewed document DL0000141 and comment as follows. I was not promoted to the Head of Cedars role. It was a lateral move at the same grade as the role I held on the Overseas Escorting contract. I remember meeting Nathan Ward at Tinsley House prior to being offered the job and being asked some questions about managing security in a low security facility. I recall thinking that the meeting was not a formal interview, which is what I had anticipated it would be at the time.

13. I do not recall speaking about the death of Mr Mubenga with Nathan Ward, but it is plausible that this was discussed as it was a fairly recent event. I certainly do not recall him expressing any concerns about me potentially managing the PDA. Similarly, I do not recall stating that I was aware that there was *"a bad culture, but managers like* [me] *were sat in an office and could not control what happened on the ground"*. Had he raised such concerns, I expect that I would remember them. Similarly, I would imagine that he would have shared such concerns with Andy Clarke.

14. I did not work with Nathan Ward so I am not sure what he means by *"typical attitude"*.

15. I was not aware that there were *"specific concerns from a number of sources that the culture of the second adjacent centre will change for the worse under Ms Newland"*. In any event, I do not think such concerns would be justified. I had successfully managed the Cedars PDA facility for 5 years before it closed. Within this role I worked alongside the children's charity, Barnardo's, caring for vulnerable families and children. Barnardo's set out 'red lines' from the outset of the operation of the facility which included: *"to speak out if the level of force used in moving people to and from the centre was 'disproportionate' or if it had serious concerns over staff behaviour, and to withdraw from the contract if these issues*

once raised were not adequately addressed".

16. Consequently, Barnardo's would have removed their support from Cedars if they had any concerns about how it was ran (which they did not do).

Relationship between Brook House and Tinsley House during the Relevant Period

17. When acting as the DD at Brook House I had a number of responsibilities. I visited all areas of the centre speaking to staff and residents. I checked Assessment Care in Detention and Teamwork ("**ACDT**") documents, chaired ACDT constant supervision reviews and chaired Rule 40 reviews. I risk assessed off site escorts, quality assured the food being served to residents, undertook on call duties once off site and opened the command suite and undertook the role of Silver Commander during serious incidents. Although I had no additional training to undertake my DD duties, I had a wealth of experience gained in managing high risk individuals in previous roles. I had also had exposure to senior management level decision making concerning management of risk, so I had transferable skills, albeit in different environments. If I did not feel safe completing the role or felt incapable of acting as DD, I would have raised it at the time.

18. With regard to the Inquiry's question, although I attended Brook House to complete DD duties / attend SMT meetings, I consider that I had limited involvement with Brook House at that time and I had no management oversight of the centre.

Verita interview - general

19. I am content that document VER000223 accurately represents the account that I provided on 5 March 2018. However, the comments I gave in that interview

were based on my feelings at the time. My opinions have changed since the interview in many respects.

Involvement in the SMT

20. During the Relevant Period, my main role and responsibilities in relation to other members of the SMT involved attending meetings to update the SMT on Tinsley House.

21. I have been asked to comment on a number of individuals. Ben Saunders was my line manager. I gave him no cause for concern, as Tinsley House was operating well. I found Ben's style to be more 'laissez-faire' and consultative than I felt comfortable with. I recall feeling frustrated during SMT meetings at the lack of decisive action and control of some of the more vocal members of the team. I believe that Stacie Dean, Michelle Brown and Duncan Partridge filed grievances against Ben, but I do not recall having sight of them and do not have knowledge of the issues contained therein.

22. I had limited involvement with Steve Skitt. He managed Brook House and I managed Tinsley House, but we had some shared responsibility for recruiting Detention Custody Managers ("**DCMs**"). At the time, I found Steve to be abrupt on occasion and indecisive, which meant that from what I could glean from SMT meetings, there was little progress in some matters. As Steve's present day line manager, I now understand that he favours clear direction and does not operate well under ambiguity. I recall that Dave Killick stated that he was going to submit a grievance against Steve (regarding a training session that Dave had travelled to, unaware that Steve had already cancelled Dave's attendance on the course). I believe that Adel Hinder also stated that she may file a grievance against Steve regarding some alleged comments that Steve had made but I do not have any further knowledge of the issues raised.

23. I had very little involvement with Juls Williams and do not recall any specific grievances being made against him. We attended SMT meetings together as he was the Residential Manager at Brook House, but he did not report to me.

24. I had more involvement with Michelle Brown once she moved into Security. I found her to be domineering and at times, I witnessed her trying to intimidate others. We had very different management styles which led to differing opinions on occasion. I also challenged her when she made incorrect statements, which others were sometimes reluctant to do. Notwithstanding these issues, I tried to support Michelle where I could, especially during her return to work following sickness absence. I am aware that Michelle had previously raised a grievance against Ben Saunders and that she raised one against me when she left her role a few years later, but I am not aware that any further action was taken. I am not aware of any grievances raised against Michelle.

25. Dan Haughton was and is knowledgeable, likeable and amenable, but during the Relevant Period in my view, he lacked direction and support and shied away from confrontation. Dan has developed into a confident and capable values-led senior manager, who is not afraid to speak up and challenge when he needs to. I do not recall being aware of any grievances made against Dan.

26. Lee Hanford took over as Director when Ben Saunders left. Lee had a more direct and action oriented style than Ben. This made a marked difference to the cohesiveness of the SMT and the progress made against longstanding issues. I do not recall being aware of any grievances made against Lee.

27. I have reviewed paragraphs 171 – 182 of document VER000226. I would not

use the words *"needy"* and *"sensitive group"* to describe the SMT. In my view, the SMT were not 'needy'. They required support and management which was not being provided by Ben Saunders at the time. I felt that there was a culture of blame and one-upmanship that was not sufficiently challenged or controlled. It was not a cohesive team.

28. On reflection, the prevalence of grievances amongst the SMT could have been as a result of frustration. If issues are raised and not dealt with, people can feel the need to take it higher to be heard. Where grievances were raised against Ben Saunders, I imagine that this was in an attempt to demonstrate to those higher up the G4S management structure the issues facing the SMT under Ben's leadership style.

Recruitment and management of DCOs and DCMs

29. I have reviewed relevant extracts of document CJS005923. DCMs received shadowing but not formal training. There was a document designed to track newly promoted DCM progress, but to my knowledge, it was never fully implemented. This has now changed significantly and there is a detailed process in place.

30. I think that DCMs struggled to get away from what was a very busy operation. This meant that their approach was task, not people focused. Staff sickness and vacancies meant that those in non-resident facing roles would be moved to manage other areas. I often saw this when I was acting as DD.

31. I agree that the demands of work meant that DCMs were unlikely to have sufficient time to devote to the Corndel apprenticeship programme. However, I am aware that the Corndel programme was not particularly relatable for some

DCMs, as it was more academic focused than practical. This impacted on certain DCMs' enthusiasm and commitment to undertake the programme.

Staffing levels

32. It is difficult for me to comment on whether or not there was a *"lack of senior management capacity"* at Brook House, as I did not spend a significant amount of time in the centre. I had a very discrete role which focused upon Tinsley House. It appears that Kate Lampard and Ed Marsden are suggesting that senior managers were too busy. From my perspective managing Tinsley House, I did not feel that I was overburdened. Although I accept that Tinsley House is a smaller site with a more compliant resident base, there were only two senior managers based at Tinsley House (Sara Edwards and I), yet we managed.

33. I agree that together with insufficient staffing levels and the rate of incidents at the time, my comments in document VER000223 were the reasons for high staff turnover.

34. The views I expressed to Kate Lampard were based on my personal experience of Brook House as a DD. They were also based on how I would have felt as a new starter amidst the high numbers of frustrated residents and the incidents that would arise as a result. Concerns regarding high staff turnover were regularly raised during SMT meetings, but my focus and role during such meetings related solely to Tinsley House. The same issues regarding staff turnover did not occur at Tinsley House (attrition was much more stable), so this was not an area that I could necessarily comment on. Had I made comments about Brook House, other members of the SMT whose focus related to Brook House, may have felt that I was overstepping my role, or commenting on issues that they felt they understood better than I did at that time.

35. Exit interviews were not routinely held with staff leaving G4S employment. However, given how challenging the role could be at times, I think that the deterioration in recruitment and retention was largely due to people being able to find easier roles in other occupations. It was a buoyant employment market in the area at that time given the proximity to the airport.

36. Prior to the reopening of Tinsley House, I recall conversations (during SMT meetings) about how Brook House would cope, as staff had become comfortable with the additional support provided by the Tinsley officers. I do not know whether an increase in headcount at Brook House was ever raised or suggested by the Director at that time, but this would have been what was required. Notwithstanding this, I believe that additional staff were brought in as a result of the additional beds as a separately negotiated addition to the contract at that time.

37. I believe that G4S did not recruit more staff to maintain the increased staffing levels, as the staffing levels in the contract with (and funded by) the Home Office, were being met. Post Panorama, contractual staffing levels at Brook House increased in agreement with the Home Office.

38. I have been asked to comment on the statements I made during my Verita interview relating to the lack of strategic planning and the experience of staff. I refer the Inquiry to my comments earlier in the interview regarding the lack of appetite within G4S to provide tenure based pay. I recall that it was a suggestion at the time, as it may have promoted the long term retention of experienced staff.

39. During my Verita interview I was asked the following question: *"In your view, would that rather complex mix suggest to you that you do need rather more experienced people, or at least people with a bit more emotional intelligence, and some life experience"*. I did not explicitly agree with those comments at the

time of my interview and on reflection, I do not agree with them now. I stated that resilience is an important quality for staff as it can be *"hard work dealing with frustrated, disruptive individuals"*. Staff faced difficult challenges and worked with residents who had different backgrounds, so emotional intelligence was required.

40. I have been asked to comment on the statement within document CJS000462 that Brook House was *"coping with staffing below contract"*. I believe this means that G4S was running Brook House below contractual staffing levels, but implementing reactive remedial measures to ensure sufficient staffing cover, for example, overtime and cross deployment from Tinsley House. Although I have limited knowledge of what was happening 'on the ground' at Brook House, my recollection was (from attending SMT meetings), that G4S was coping with meeting the daily staffing levels required by the Home Office.

41. I do not recall specific steps to address staffing levels on the wings. Document CJS000913 suggests that staffing levels on the wings were adequate, but a high number of external escorts and constant supervisions were taking staff away from the wings, an issue which was compounded by absence levels. I would agree with this observation. Generally, we could manage with the number of staff assigned by G4S. The main issue arose when those staff members were pulled from their duties to assist elsewhere, for example, external escorts.

42. I do not recall Michelle Brown stating that managers needed to give support to staff. I do not recall whether this was passed to DCMs following the meeting on 11 August 2017 and I cannot comment on what steps were taken to ensure that more support was given.

43. I do not recall whether the new mentoring process referred to in document CJS000918 was implemented. I do not know what steps were taken to address

the fact that DCMs were not managing staff / DCOs were not taking responsibility for managing simple issues, but I believe that there was an effort to be more structured when mentoring staff. This is likely to have been an area that Juls Williams would have managed, but he did not report to me and therefore I cannot comment further.

44. I do not recall what I meant when I said *"it's an issue that I have had raised in other roles"*, but this may have been a reference to my time at Cedars or on Overseas Escorting as I do recall reviewing line managers and ensuring that they worked with the staff that they were expected to monitor and support.

45. At Tinsley House DCMs reported to Sara Edwards and I, and were managed effectively. I can only imagine that this comment relates to my reflections on staff at Brook House.

46. I note that I stated that I did not think enough effort was made by DCMs to engage with staff in document VER000223. By this I mean that operational tasks, such as ACDT reviews and first response, featured more predominantly in their minds when compared with broader managerial responsibilities, like staff engagement. I shared my views at SMT meetings, but was limited in what practical steps I could take to address these issues, as routine management of Brook House was outside of my remit. Consequently, my ability to influence senior managers working at Brook House was limited.

47. I do not know what Steve Skitt meant when he stated "*DCMs consider themselves to be operators and are not developing talent"* in the SMT meeting on 3 May 2017. The comment suggests that Steve thought that staff were too busy conducting routine operations, that they did not have time to manage their staff. This would be a fair reflection based on my knowledge of the Relevant Period. To address this issue, I believe that staff had regular employee

development reviews and general performance reviews that were already in place.

Staff culture

48. During the Relevant Period, I would describe the culture amongst the SMT as being fractured, confrontational and mistrustful. I felt that certain members of the SMT focused on their own performance progression, rather than that of the team. There were trusting relationships between individuals within the SMT, but there was a lack of trust within the team as a whole.

49. It is difficult for me to comment on the culture amongst DCOs / DCMs at Brook House, as my role was based at Tinsley House. Therefore, any opinions I give are largely based upon anecdotal evidence, or my experience during DD shifts which is limited. On the whole, I felt that DCOs and DCMs were stressed and stretched. However, most tried hard to undertake their role well, despite these pressures. It could be a difficult place to work at times and I do not think that they always felt supported by the SMT, due to the lack of presence of the SMT 'on the ground'.

50. I have been asked to comment on the reference I made to the *"desensitisation"* of Brook House staff during my Verita interview. As I attended Brook House sporadically, and as a result of my experience working at Cedars, I believe I saw things from a different perspective. I could see that the toll of high numbers of residents, incidents, threats and aggressive behaviour meant that staff felt stuck in 'here we go again' type of situations. They did not have the time or energy to reflect on what was driving the behaviour from residents, or to consider what could be done to try and address the causes. Staff were often dealing with matters reactively and did not have sufficient time to take proactive action to tackle the root cause of such issues.

51. In my dealings with residents as DD during the Relevant Period, I would always try to understand what was causing challenging or disruptive behaviour to try and manage the cause, not the effect. I saw examples of staff taking admirable steps to try and manage residents with, for example, mental illness, together with examples of very compassionate behaviour. I would always provide positive feedback when I saw this in practice.

52. I do not recall whether Ben Saunders described Stacie Dean's absence from work as *"ridiculous behaviour from a Senior Manager"*. It is not a comment I would readily associate with Ben and his management style.

53. Although I was aware of specific incidents and allegations of bullying (through the investigations I was asked to undertake), I was not aware of *"incomprehensible levels of bullying"* at Brook House. Bullying is a serious accusation relating to a pattern of consistent and maliciously intended behaviour. Therefore, I sometimes felt that the word 'bullying' would be used too readily to describe unfortunate incidents that although wrong, would not constitute bullying on the evidence presented. By way of example, making an isolated comment to another member of staff is unlikely to be considered bullying on its own.

54. With regard to document CJS0073634, I recall investigating an allegation that Steve Skitt had made the *"disgusting"* comment. I also understand that Gayatri Mehrra sometimes spoke in her mother tongue with colleagues. Aside from these matters, I do not recall being aware of the other allegations raised therein.

55. Of the behaviour described, I have only personally witnessed Gayatri speaking in her mother tongue. As someone who speaks a second language, I did not have any concerns with this. However, I can understand that others may not like this,

as it can make one feel that others are talking about them.

56. I recall that Duncan Partridge and Ben Saunders did not see 'eye to eye'. Duncan would sometimes make comments to me (when we occasionally met) about how stressed he felt. These comments suggested that there was tension between them. However, to my knowledge, this predated the Relevant Period.

57. I was not aware that Duncan Partridge had made comments about Ben Saunders' management style.

58. I worked at Cedars when Duncan Partridge was the Deputy Director. There would not have been any reason for conflict between us, nor do I recall any. For clarity, Duncan was not in a relationship with my sister as suggested in document CJS0073667. He was in a relationship with a nurse that worked with my sister. I believe that my sister was interviewed by the Managing Director at the time regarding a comment that Duncan had made. However, I do not recall what this comment was, or what it related to.

59. I have been asked to comment on my suggestion in document CJS000575 that *"the ITC could observe roll count, lockup etc. from the Control room to give them an overview"*. New starters were not permitted in the centre at that time without clearance. I suggested that they could view some resident areas from the control room CCTV cameras to give them some insight into the centre's environment and activities (rather than having no insight). I do not recall whether this suggestion was implemented and I would not be able to comment on why this was the case.

60. Currently, new starters have a tour of the centre so they have a better understanding of the environment before 'going live'.

Centre culture and environment

61. The additional beds at Brook House resulted in an increased number of residents in the same sized bedroom. Although staff numbers increased to reflect the additional beds, there were more residents on the wings and more in the centre, without any extension or expansion of the services offered. This only added to resident frustrations.

62. D87 was subject to a lengthy period of Rule 40 due to threats he had made to cause disruption. During my shifts as DD, I had the opportunity to speak to D87 at length on at least one occasion. He was very frustrated about the actions taken against him. Typically, incremental adjustments are made to the regime of residents on Rule 40 to test their compliance and ascertain whether their threats are credible. This did not occur with D87 and he was subject to the strictest conditions, which unsurprisingly caused him to become more upset. He also suggested that the approach being taken with him was driven by Michelle Brown at the time.

63. I am aware that other residents who made similar threats were not treated in the same manner as D87. Therefore, in my view having spoken to D87, the actions taken against him seemed to be disproportionate.

64. The criticism in my comment is largely aimed at Michelle Brown, as my recollection is that this situation was as a result of her instructions. D87's comments suggested that she had made things 'personal', which made me feel that D87 was being treated more robustly than other residents at the time.

65. With regard to document CJS000913, I vaguely recall the incident, but I was not involved in monitoring use of force ("**UOF**") at Brook House at that time. Therefore, I do not know what lessons were learned from the four staff members

being injured.

66. I did not make the decision to turn the multi-faith room at Tinsley House into a bedroom. The allocation of space within the IRC is a Home Office decision and in any event, I believe this decision would have been taken before I joined Tinsley House.

Grievances

67. During the Relevant Period, I investigated grievances at the request of the Director, Managing Director or HR Business Partner. I investigated grievances at both Brook House and Tinsley House, but the majority of grievances related to Brook House. I do not know why I was asked to investigate so many grievances. I can only assume that I was perceived as independent and fair. Senior staff also knew that I conducted thorough investigations.

68. I am not sure what is meant by *"amnesty from grievance is to end"* in document CJS000463. I was still managing Cedars at the time.

69. The outcomes of the grievances listed in document CJS000473 appear to be detailed on the spreadsheet. I cannot recall any additional details in relation to these three grievances (save for the grievance relating to David Waldock, which is referred to below).

70. I was the investigating officer for the grievance raised by David Waldock. Juls Williams was investigated as part of the investigation.

71. I have been asked to comment on whether I spoke to any other members of staff involved in this grievance beyond Juls Williams and Steve Skitt, but I do not recall whether or not I did this.

72. Although I am not medically trained, when I interviewed David Waldock he appeared to be exhibiting behaviour that lay people would associate with paranoia. I believe that he was on sick leave at the time and I recall him describing some personal issues that seemed rather extraordinary. I was concerned for his wellbeing and encouraged him to see a GP.

73. David Waldock's belief that Steve Skitt was homophobic was solely based on Steve's use of the word *"disgusting"* within David's vicinity. The explanation provided by Steve and Juls Williams was that they were discussing the state of the showers at Brook House, not David, and certainly not David's sexuality. The explanation provided was entirely plausible because the cleanliness of the showers was a 'hot topic' at the time and there was no evidence to suggest that David had been targeted in any way as a result of his sexuality.

74. With regard to document CJS0073398, I recall meeting with Adel Hinder and discussing her concerns. She was worried about reporting her concerns because of Steve Skitt's role and rank and she was seeking my advice in relation to this. I informed her that if Steve had used the homophobic terminology alleged, she should report it formally using the correct processes, so it could be investigated. I do not recall whether this was before or after she submitted her formal complaint. I recall that the allegation surprised me at the time, as I had no reason to think that Steve was homophobic.

75. Steve Skitt was suspended for a period pending the investigation. I believe that the matter was investigated by someone outside of the contract. I did not see the investigation report and was not privy to any follow up actions.

76. I did not notify anyone of the previous allegation against Steve Skitt (that he was homophobic to gay men), as the previous allegation I had investigated was

not substantiated. Therefore, it would not have been fair to take it into account as part of the Adel Hinder complaint.

77. For clarity, a disciplinary officer takes into account previous disciplinary sanctions when reaching their conclusions. It would not have been appropriate for me to repeat uncorroborated, unfounded allegations and if I had done so, it could have severely prejudiced any investigation.

78. I do not recall the bullying grievance raised by DCM Adam Clayton against Nathan Ward. I think that it concerned Nathan's behaviour towards Adam regarding an incident, but I cannot recall the incident or the outcome of the investigation.

Reporting and whistleblowing procedures

79. The whistleblowing process / procedures were used during the Relevant Period, but I did not have intimate knowledge of them. I recall someone commenting that it took a long time to get through the automated screening questions to speak to someone.

80. The anonymous whistleblowing claim against Neil Davies concerned Neil's behaviour, management style and comments he made. I believe that I interviewed over ten employees and there was a clear trend within their evidence. After I had interviewed Neil, he asked Ben Saunders if he could resign with immediate effect. I did not see him again. I was still in my role at Cedars at the time that these allegations were said to have occurred. Once again, I believe that I was asked to investigate the matter as I was viewed as independent.

81. I have reviewed documents INN000007 and INQ000101. I do not know which

officers this report concerns and Owen Syred states that he did not tell me the officers' names. I do not recall what steps I took following this report, but the steps I could take would be limited, as I did not know who was involved. I expect that I would have raised the concerns with managers, so that they could be vigilant and challenge appropriately. I do not recall the issue being raised with me again.

Disciplinary matters

82. I was involved in disciplinary matters at Brook House and would be assigned as investigating officer or disciplinary officer by the Director or Managing Director. I would be issued with terms of reference and proceed accordingly. Again, I do not know why I was asked to deal with so many disciplinary matters. I can only assume that I was perceived as independent and fair, which is supported by the fact that very few of my decisions were appealed. Senior staff also knew that I conducted thorough investigations and hearings.

83. I do not recall a time where someone has placed pressure on me to dismiss an individual during a disciplinary investigation. I would not allow myself to be pressurised into unfairly dismissing someone. It would not be fair or proper for an individual to be dismissed unless the threshold for dismissal had been reached.

84. I do not recall how many disciplinary matters I was involved in per month around the time of the Relevant Period. I may not have been involved in any disciplinary matters during some months, whereas in others, I may have conducted more.

85. I worked closely with Joe Marshall in my role at Tinsley House. He was balanced and measured, so I do not believe that he would have stated that there

was a culture of fear of management without foundation. Although that was not my personal opinion working at Tinsley House, I do not know how staff felt in Brook House. Joe was a union representative, so his opinion may have been based on information gathered whilst speaking to staff.

86. I do not believe that the terminology used in disciplinary outcome letters was used in an overly 'heavy-handed' manner. There was never an intention to intimidate staff. We were simply encouraged by HR to ensure that staff understood the implications of further misconduct.

Specific involvement

87. I have reviewed document CJS000473. I do not recall the Ben Mortimer Cook investigation. I recall that Lia Winston worked in the shop, but that she would see specific residents on the wings to possibly pass prohibited items. I believe that Lia left Brook House, but I do not recall how or why.

88. Kye Clarke jumped on to the back of a resident who was threatening to climb onto the netting (or who had just been on the netting) between the floors of Brook House. He was not asked or instructed to do this. He appeared to have made the decision himself. He also took his shoes, belt and keys off and left them unattended in a stairwell. The document suggests that he resigned.

89. Document CJS0073338 relates to the grievance against Neil Davies, referred to above.

90. I have reviewed documents CJS0073004 and CJS0073524. I was the disciplining officer and issued a final written warning to Lia Winston.

91. I have reviewed document CJS0072961. I was the disciplining officer and

summarily dismissed Chelsea Steele.

Interaction with detained persons

92. During the Relevant Period I visited all areas of the Centre whilst completing the DD role. I was often approached by residents and asked who I was, as they did not recognise me. I would explain and engage in conversation if they wished to. I also chaired ACDT constant reviews and Rule 40 reviews, which often involved lengthy conversations with residents, depending on the individual's circumstances at the time.

93. During the Relevant Period, I tried to be as visible as possible around Tinsley House and Brook House (when completing DD duties).

94. Although the pandemic has impacted my ability to be visible across both IRCs, in my role as Deputy Director I continue to adopt an open approach today and I encourage an open door policy amongst staff. I also attend Brook House three times per week and Tinsley House twice per week for morning meetings.

Detainee behaviour

95. I have reviewed documents CJS004689 and CJS005446. Threats towards staff carrying out their role were relatively commonplace, especially where rules were being reinforced. Threats to take staff hostage were far less frequent. I do not recall receiving any direct threats myself.

96. Such threats had a varying level of impact, depending on the situation and relationship with the resident. If a staff member had a good relationship with a resident and for example, the resident swore at them after receiving bad news, the staff member may be able to contextualise the resident's abusive language /

threatening behaviour. However, if more serious threats were made, especially from residents who were not known to staff, the impact would be far more damaging, as staff may fear for their safety, especially if the threats alluded to what could happen outside of the workplace.

97. It was not unheard of for residents to boil water to throw at staff / threaten to do so. This was usually in response to the issue of removal directions, or as part of an incident. Such threats worried staff, as boiling water can leave lasting damage. To combat such threats, planned removals were conducted to ensure that staff were wearing suitable personal protective equipment. We could also cut the power to individual rooms to allow time for any boiling water to cool.

98. I was DD at the time of the incident referred to in document HOM000667. I remember attending Brook House to manage the incident as the Silver Commander. When I arrived, the residents had all come in voluntarily and the incident was effectively over.

99. I have reviewed documents CJS005254 and CJS005297. The previous *"courtyard disruption"* appears to be a reference to the incident that I attended on 14 July 2017.

100. I do not recall sufficient details of the second incident to comment on whether pre-emptive steps were taken.

101. I have reviewed document CJS000918, but I cannot comment on the actions of the management team at Brook House to manage such concerns, as my role was focused on Tinsley House (where assaults were far less frequent).

UOF and restraint

102. During the Relevant Period, the expectation was that DDs would attend all planned UOF incidents. Although I always ensure that I attend control and restraint ("**C&R**") refreshers and remain 'in ticket', I would not play an active role in the UOF. My role would be to oversee the incident as a whole, to ensure that the actions and behaviour of staff were proportionate and reasonable and that the welfare of the resident was maintained.

103. Unless I was present when an unplanned UOF occurred, I would usually be informed about the event after it had occurred. I would typically be aware if an incident occurred within the centre due to response calls on our handheld radios. Whilst DDs would not attend first response incidents, if I could hear that an incident was continuing for a significant period of time, I may attend the scene to assist where I could.

104. I have reviewed document INQ000078. In my opinion, only a minority of staff enjoyed being more 'hands on' than they should. I would suggest that this figure is less than 10% of staff.

105. I do not know why Dave Webb and Jason Riggs felt that they were able to make such comments within the training session. The comments surprised me as they were not acceptable or, in my view at that time, representative of the wider culture at Gatwick IRCs. They were grossly inappropriate and are not comments that I have heard on my C&R refreshers. Please note, Jason Riggs worked at HM Prison Parc.

106. My decision to issue Dave Webb a verbal warning was an appropriate sanction proportionate to the findings of the investigation. The Inquiry appears to suggest that a decision I made in 2017 was insufficient or questionable, based on comments that Dave made the following year. I could not have known that Dave would go on to make those comments in the training session almost a year later.

It is unclear to me how I can comment on whether present day disciplinary decisions could be impacted by future unknown events.

107. As the Head of Tinsley House (where force was used infrequently), I had no direct responsibility for the day to day management of Brook House, including UOF reviews. Therefore, I am unable to comment on them, or their frequency.

108. I have reviewed document CJS000495. I was managing Cedars in March 2016, so I am unclear of my role in this meeting, or whether the minutes have been recorded properly. The minutes are fairly confusing, as I would not associate UOF governance at Brook House with minimising and managing physical restraint ("**MMPR**"). UOF at Brook House was and is limited to C&R.

109. In any event, MMPR coordinators (instructors) were available for the PDA at that time.

110. In my opinion, C&R is not the most important aspect of the initial training course. However, it is one of the elements (together with first aid) that potential officers need to pass to continue in the role of DCO. This made it a focal part of the course, together with first aid.

111. I was not aware that C&R was being treated as a rite of passage. From experience, I know that there can be anxiety that precedes involvement in your first UOF event, as prior to this, you would have only received classroom based experience. This may explain why some people felt that it was a rite of passage, but that is certainly not my impression of C&R.

112. During the Relevant Period, I am not aware that staff intentionally provoked situations / detainees, so that they might have to use force on them. If such a situation was reported, it would be investigated and managed under the

disciplinary policy as a contravention of DC Rule 41, which specifically states that such action will not be tolerated:

"(2) No officer shall act deliberately in a manner calculated to provoke a detained person."

Healthcare

113. At the time of document NHS000015 I was managing the Cedars facility. Therefore, I cannot comment on, and have no knowledge of the steps taken to address these concerns.

Complaints

114. I did not investigate complaints from residents, as these would be sent directly to the Home Office (and returned to managers who worked at Brook House for further investigation), but I did investigate complaints made by staff at Brook House if requested to do so by the Director or Managing Director.

115. I have reviewed row 33 column I of document CJS000524, but I do not recall this matter.

116. The incident involving Darren Tomsett occurred many years ago. I was involved in a number of investigations / matters at the time and therefore do not recall specific information about this incident.

Security / drugs

117. If I had suspicions of drug usage within Brook House whilst I was present in the centre as DD, I would submit an SIR. As DD I would also be contacted to

authorise a full search if there was a suspected drug pass in visits. However, outside of this, I had limited involvement in preventing the ingress of prohibited items into Brook House.

118. I do not know what steps were taken to address drug use on the 1st floor of C-wing. I imagine that this was a concern for the security and residential managers.

119. In March 2016, I was managing Cedars PDA and had not yet begun to complete DD duties, so I am unable to comment on what was done to address the fact that there was *"no consistency in Security as staff are being taken away from their jobs to cover other areas"*.

120. I have reviewed documents CJS005108 and CJS005470. I submitted an SIR because I could smell marijuana whilst on duty at Brook House. I do not recall the details of this incident, but from reading the documents, I surmise that I would have wanted to have a broader discussion with the Head of Security, rather than acting in isolation without access to all of the information. Acting in a rash manner could have compromised the work being done to identify the route of ingress. I do not recall what steps were taken after this incident.

121. I do not know whether any of the suggestions referred to in document NHS000014 were implemented. I had limited experience of new psychoactive substances ("**NPS**") through my work as DD. However, the management of NPS / other drugs at Brook House was outside of my remit as Head of Tinsley House.

Commercial matters

122. I was not responsible for monitoring G4S' performance at Brook House during the Relevant Period. I was responsible for Tinsley House, so I do not have sufficient knowledge to comment on the questions raised by the Inquiry.

123. With regard to penalty points, I had some involvement in investigating why Tinsley House received them and whether there were any mitigating circumstances. However, I would not have dealt with the penalty point system at Brook House.

124. It is important to contextualise the comments I made in document VER000223 about the Director making the contract profitable. Where I state *"agree"*, I am talking from the perspective of a hypothetical Director, rather than giving my agreement. My comments are an acknowledgement that those practices could, in theory, make the contract more profitable.

125. With regard to my comments, there was a fixed fee paid to G4S per month by the Home Office. Within my role at Cedars (before ever working at Brook House or Tinsley House and before the Relevant Period), I attended Trading Reviews to report to the Managing Director. Ben Saunders would also attend these meetings, so I was given an insight into the pressures (referred to in the paragraph below) facing Ben.

126. I was aware that Brook House would often be run below staffing headcount, with staff vacancies left open. Whilst required staffing targets would usually be met operating in this manner (for example, through the use of overtime and cross deployment), the practice meant that salary costs were saved by G4S. From the Trading Reviews I attended, I got the impression that there was pressure from those higher in the management structure to make these saving where possible, so that such savings could be offset against other more onerous contracts held by G4S.

127. For clarity, when I began my role at Tinsley House, I do not believe that I continued to attend Trading Reviews, so I do not have more recent knowledge

of this. However, I expect that I continued to hear about such matters through my attendance at SMT meetings.

128. I have reviewed paragraph 276 of document VER000223, but it appears that Kate Lampard (rather than I) is quoting these hypothetical figures as an example. I would disagree with the comment, as in my experience there were generally sufficient staff to cope with standard operations. However, issues typically arose when staff were pulled away from their allocated role to deal with incidents or other operational matters, or when absence levels were high. Therefore, it is difficult to say that a conscious decision was taken to deliberately understaff the wings.

129. In general, lower staffing levels compromise operational stability and this can impact the welfare and safety of staff and residents. Staffing levels were a regular discussion point at SMT meetings and to my knowledge such issues were regularly raised with Ben Saunders. Therefore from the SMT's perspective, the issue was raised to the appropriate level and there was an expectation that Ben would escalate the matter further. I would not be privy to discussions beyond that point, but I expect that Ben would have raised such concerns with more senior individuals.

Cleaning

130. I have reviewed documents CJS000462 and CJS000503. Document CJS000503 reads as though Juls Williams and I had been told that the service would change, perhaps by local managers, in contrast to what was stated at the SMT meeting. In any event, at the time of document CJS000462 I was still based at Cedars, so would not have knowledge of these issues at Brook House.

131. On the whole, the service offered by Aramark at Tinsley House was satisfactory,

but there were times when I considered it inadequate, for example, if I found dust in the stairwells, or dead flies on windowsills.

132. Having attended meetings held by Steve Skitt with Aramark managers, I recall that cleaning standards at Brook House were raised with their management team. However, I attended these meetings to represent concerns relating to Tinsley House.

Panorama broadcast and aftermath

133. I recall being made aware of the Panorama broadcast before it aired, but I do not know the exact time and date. When I was notified that a programme would air, I was surprised as I had no inclination that a member of staff had been covertly filming at the centre. At the time, I did not have knowledge of the incidents that were displayed within the programme, so I expect that I was wondering what would / could be shown.

134. I was not aware of any of the mistreatment shown, or any of the mistreatment recorded in Callum Tulley's log.

135. I cannot explain what drove staff to mistreat residents. The centre could be difficult to manage, with high rates of incidents, self-harm and UOF. I can see how operational stress could result in staff being more readily provoked by abuse or threats. However, that does not justify physical assault or some of the dismissive behaviour shown towards those in crisis.

136. I was shocked and saddened by what I saw and it was very uncomfortable to watch. It was also slightly surreal to see staff behaving in a manner that I would never associate with them.

137. I felt that the programme discredited the excellent work that the majority of staff did on a daily basis and it failed to provide a balanced reflection of life at Brook House. I was also incredibly angry that Callum Tulley had evidence of this behaviour and failed to bring it to the attention of the SMT or the Police. Had he done so, effective action would have been taken, which may have prevented some of the incidents that we witnessed in the programme.

138. Although I do not agree that senior management at Brook House during the Relevant Period have direct responsibility for what occurred, it would be unreasonable for me to state that senior management did not have partial, indirect responsibility. Culture within IRCs has to be driven by senior leaders. I have reflected above on a number of issues that I think were prevalent during the Relevant Period, for example, the friction and lack of cohesiveness amongst the SMT, the laissez-faire style of Ben Saunders and the commercial pressures from G4S when managing staff levels. These factors may have contributed to creating an environment within which such incidents could occur and remain undetected.

139. Whilst I agree that only the individuals shown within the footage are responsible for the shocking acts that they conducted, for the reasons set out above, I do not think that it would be fair to say that they are the only ones responsible when holistically considering the environment / culture at Brook House during the Relevant Period.

140. I would not describe the abuse shown in the Panorama broadcast to be foreseeable. I have a number of years' experience working in such environments and am therefore accustomed to managing staff who regularly deal with incredibly difficult situations and residents. Despite the pressure this places on officers, I could not foresee a situation where a member of staff would act in such a violent or oppressive manner towards a resident. In hindsight, I can see

how the atmosphere at Brook House, pressures on staff and the lack of oversight created an environment where unacceptable behaviour could occur unnoticed.

141. I was briefed to conduct a number of disciplinary matters following the airing of the Panorama broadcast, but I was never given any advice or instructions as to the decisions I should reach. I recall a conversation with Lee Hanford where we made clear that individual decisions would be based on individual cases, and that staff were entitled to a fair hearing in line with G4S policies, ACAS guidance and employment legislation. Lee agreed that decisions should not be prejudiced by the spotlight of the documentary.

142. The Inquiry has referred me to a number of disciplinary decisions that I made at the time. Almost five years has passed since I made those decisions, so it is almost impossible for me to recall the reasons why I made particular decisions, or the incidents that prompted the disciplinary proceedings. Having reviewed a number of documents identified by the Inquiry, in particular my outcome letters, I can see that I undertook a thorough approach, ensuring that staff were given clear reasons for my decision.

143. Given my lack of ability to recall these matters in great detail, I have provided similar answers to many of the Inquiry's questions below. I mean the Inquiry no disrespect in doing this.

144. I have reviewed document CJS006639 relating to Daniel Small. I did not investigate this matter. I chaired the disciplinary hearing and the reasons for my decision are contained within the outcome letter. I can add no further detail at this time.

145. I would only have been aware of such comments if they were included as part of the investigation report, which I would base my decision on. If the comments

were not in the report, I would not have been aware of them. They are not referenced in my outcome letter, so it would appear that they did not form part of the investigation.

146. I was not aware that DCO Small had described an incident where Derek Murphy *"choke slammed"* a detained person.

147. If I had been aware of such comments, they may have changed my decision, but only if the investigation had concluded that there was sufficient evidence to suggest that they had been made.

148. It is also not clear to me when such comments were brought to G4S' attention. If they were not sent to G4S ahead of the investigation, then they would not be included within the investigation report. It follows that I would then be unaware of such comments when considering the disciplinary sanction.

149. I have reviewed documents CJS0073297, CJS0072996, CJS0072973 relating to Dave Webb, Darren Tomsett and Charlie Francis respectively. I did not investigate these matters. I chaired the disciplinary hearings and the reasons for my decisions are contained within the outcome letters. I can add no further details at this time.

150. I have reviewed document CJS0073011 relating to Derek Murphy. I did not investigate this matter. I chaired the disciplinary hearing and the reasons for my decision are contained within the outcome letter. I can add no further detail at this time.

151. Unless the following information was contained with the investigation report, I do not recall being aware: that DCO Lake described seeing Derek Murphy upper-cutting a detainee; that DCO Small was alleged to have described an

incident when Derek Murphy *"choke slammed"* a detained person; that D2953 had alleged in June 2017 that Derek Murphy punched him three times; or that D1747 had alleged in June 2017 that Derek Murphy had hit him twice in the chest.

152. I have reviewed document CJS0073133 relating to Daniel Lake. I did not investigate this matter. I chaired the disciplinary hearing and the reasons for my decision are contained within the outcome letter. I can add no further detail at this time.

153. I was not aware of the comments made by DCO Lake, or the fact that DCO Lake described seeing Derek Murphy upper-cutting a detainee. I would only have been aware of such comments if they were included as part of the investigation report, which I would base my decision on. If the comments were not in the report, I would not have been aware of them. They are not referenced in my outcome letter, so it would appear that they did not form part of the investigation.

154. Again, if I had been aware of such comments, they may have changed my decision, but only if the investigation had concluded that there was sufficient evidence to suggest that they had been made.

155. It is also not clear to me when such comments were brought to G4S' attention. If they were not sent to G4S ahead of the investigation, then they would not be included within the investigation report. It follows that I would then be unaware of such comments when considering the disciplinary sanction.

156. I have reviewed document CJS0073302 relating to Chris Donnelly. I did not investigate this matter. I was tasked with meeting Chris following an investigation undertaken by G4S Director, Pete Small and his team. I also

chaired a disciplinary hearing with DCO Ben Opoku for his part in the same incident. I issued this letter to reiterate the expectations required of Chris and to record the conversation that we had had regarding the incident. I recall that the justification provided for Chris' inaction (that he believed that DCO Opoku had already reviewed the scene and removed any ligatures) was considered reasonable and therefore, it was only deemed necessary to take formal disciplinary action against DCO Opoku.

157. I have reviewed document CJS0073341 relating to Sean Sayers. I did not investigate this matter. I chaired the disciplinary hearing and the reasons for my decision are contained within the outcome letter. I can add no further detail at this time.

158. I was not aware of the comments made by Dan Lake about this incident to Callum Tulley.

159. If I had been aware of such comments, they may have changed my decision, but only if the investigation had concluded that there was sufficient evidence to suggest that they had been made.

160. It is also not clear to me when such comments were brought to G4S' attention. If they were not sent to G4S ahead of the investigation, then they would not be included within the investigation report. It follows that I would then be unaware of such comments when considering the disciplinary sanction.

161. I have reviewed document CJS0073480 relating to Stephen Webb. I did not investigate this matter. I chaired the disciplinary hearing and the reasons for my decision are contained within the outcome letter. I can add no further detail at this time.

162. I was not involved with the action plan formulated with the Home Office following the airing of the Panorama documentary. I was based at Tinsley House at the time and I recall that Lee Hanford and Steve Skitt often attended meetings in London to work on the plan / held separate internal meetings to discuss it.

163. I disagree with the characterisation described in Callum Tulley's statement. Although there are elements that I concur with, for example, the lack of real oversight and engagement from Ben Saunders, at that time I did not feel that there was a *"culture of silence"*. If anything, as demonstrated above by the number of grievances and complaints made by staff, I believed that staff were far from silent.

164. I would also disagree that an abusive culture was allowed to fester and go unchecked at Brook House. Had I been aware of the horrific behaviour demonstrated on the programme, I would certainly have taken decisive action to ensure that it did not reoccur. In this sense, I was incredibly disappointed and angry that Callum Tulley allowed such incidents to occur and failed to report them to senior staff, or the Police. His actions undoubtedly undermined the safety and wellbeing of residents.

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	Sarah Newland
Signature	**Signature**

Date	11 March 2022