BROOK HOUSE INQUIRY

First Witness Statement of Sara Edwards

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 15 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, **Sara Edwards**, will say as follows:

Introduction

1. I have worked in the immigration estate since 2005. Between 2005 and the end of 2008, I worked as a Detention Custody Officer ("**DCO**") for Serco based at Colnbrook Immigration Removal Centre.

2. I commenced my employment with GSL / G4S on 5 January 2009, as a DCO. I was promoted to the role of Detention Custody Manager ("**DCM**") in May 2009. I worked at Brook House in the role of both Oscar 1 and Oscar 2. I subsequently transferred to Tinsley House in August 2011 as an Oscar 1.

3. In 2012, I became the Safer Community Manager at Tinsley House. In February 2014, I successfully passed a board and was seconded into an E1 role as Operations

& Residential Manager based at Tinsley House. In or around May 2014, the Head of Tinsley House position was advertised, but I was unsuccessful at board.

4. In 2016, I was substantiated into my E1 post as Operations & Residential Manager based at Tinsley House. In May 2018, I was asked to perform the role of Head of Safeguarding (a D1 position) on a seconded basis. This ceased in January 2019, after I unsuccessfully applied for a fulltime post in this role. However, I remained within the safeguarding function assisting the new Head of Safeguarding.

5. In July 2019, I transferred back to Tinsley House in my substantiated E1 role as Operations & Residential Manager at Tinsley House. The service provider then changed in May 2020 and due to a restructure of the Senior Management Team ("**SMT**"), I was placed into a Duty Operations Manager ("**DOM**") role.

6. I have a Chartered Management Institute Level 5 professional qualification in Leadership & Management, which I gained in July 2019 through Corndel.

Culture

7. In my opinion, the management and leadership culture at Brook House was at times disjointed. There appeared to be instances of miscommunication, or communications that changed at short notice which created confusion. From my experience being based at Tinsley House, information was not always delivered and / or changed. Some meetings / discussions around particular issues would be completed prior to morning meetings commencing. Therefore, I was not always privy to such discussions.

8. I always felt that the Director was approachable and I had no issues with speaking to him or asking questions. In my opinion, there was a focus on service delivery and contractual obligations, but also on care, decency and the well-being of detained persons.

9. I am unaware of any occasions where concerns were raised about the treatment of detained persons at Brook House during the Relevant Period, or after that date. Had concerns been raised, whether informally or as a 'whistle-blower', my understanding is that the issues would be fully investigated. However, I cannot recall any investigations and I do not recall being asked to investigate any myself.

10. I do recall one occasion where a DCO made an inappropriate comment in front of me. I reported this and the incident was investigated. The DCO was subsequently dismissed.

11. Although I was based at Tinsley House, whilst working as part of the SMT I was aware that a number of grievances had been submitted against other members of the SMT. However, I was not privy to the facts or nature of most of these grievances. The grievances made the team disjointed. There was a lack of trust and the team no longer worked cohesively. There was often confusion around strategy and outcomes and it felt as though everyone was pulling in different directions. There was also conflict between different directors.

Policies and procedures

12. At the point that document CJS000721 was produced, I was part of the SMT. Therefore, it would have been produced by the Head of Function and their staff group. I was a Safer Community DCM until February 2014, so I may have been asked for input in relation to Tinsley House procedures, but I cannot recall this.

13. I believe document CJS000721 was in place during the Relevant Period. I recall a Disruption Policy being produced and implemented, but I cannot confirm when this happened. However, I am aware that it was produced by Steve Skitt.

14. At the time document CJS000721 was created, I believe the role of Safer Custody Manager (DCM) was James Begg.

15. When I assumed the role of Head of Safeguarding, I do not recall making any specific changes to document CJS000721. However, I would have reviewed it and sent it to the Home Office for sign off and approval. This was completed annually, or if there were any changes to a Detention Services Order ("**DSO**") that we were notified of.

16. The SMT were notified daily of any detained person who was refusing food and / or fluid. This would be via the daily operations report. The detained persons were RAG rated (green, amber and red) with red being the most serious in terms of refusal and length of time. Meetings took place with the SMT and Healthcare to discuss individual cases where required. Healthcare would monitor the health of detained persons from a medical perspective and the SMT would involve the Home Office where necessary, if the refusal was related to a case issue.

17. I believe that after the Relevant Period, in or around 2019, the SMT discussed all food / fluid refusals after the morning meeting, with Healthcare and the Home Office present. The Duty Director ("**DD**") took responsibility for updating a food / fluid refusal diary, which was brought to each of these meetings daily and kept in the Director's office.

18. Document CJS007076 would have been reviewed annually, or if there were any changes to a relevant DSO. The document would be sent to the Home Office for approval and sign off. To my recollection, I reviewed all of the policies and procedures that were within my remit as Head of Safeguarding and any that were within my remit as the Operations & Residential Manager at Tinsley House.

19. Checks were completed on the Assessment, Care in Detention and Teamwork

("**ACDT**") documents by the Safer Community Manager, the Residential Wing Managers and by the nominated DD as part of their daily responsibilities whilst performing the role of DD (where they reviewed and signed each individual document that was in use).

20. The 12 hour shift pattern changes meant that often, ACDT Assessor or ACDT Case Manager trained staff were carrying out multiple reviews per day, during a time when staffing numbers were already low. Staff who were rostered on ACDT constant observations would in some instances perform this duty for longer than two hours, or would be switching between different residents who were on constant observations for the duration of their shift.

My role and work at Brook House

21. E-wing was predominantly used for residents who were leaving on charter flights and escorted removals, or for residents for which staff had received information that they may cause disruption. E-wing was also used to house residents who claimed to be under the age of 18. They were either awaiting collection by Social Services, or in some instances, awaiting a transfer to Tinsley House.

22. Room E001 was used by residents detoxifying from drug withdrawal. Other residents who may reside on E-wing included those with mental health issues, or those that had been placed in rooms 007 and 008 for the purposes of ACDT constant observations. E-wing was also used to deescalate residents who had previously been located in the Care and Separation Unit ("**CSU**") on either Rule 40 or Rule 42 regimes. This formed part of a reintegration programme back to the normal population.

23. Many different processes occurred on E-wing depending on the resident and the reason they were based on E-wing, for example: residents were assessed and

risk assessed; constant observations were maintained; drug withdrawal programmes were managed; age disputes were assessed prior to release into the care of Social Services or transfer to Tinsley House; and charter flight / escorted removal residents were prepared for discharge.

24. Residents on E-wing were encouraged to take part in activities and had access to the Centre and its facilities at times differing to those on other wings. In some instances, some residents were able to freely leave E-wing depending on their individual circumstances. Some activities / education was provided on the wing and residents were escorted to use the gym facilities. Legal and social visits were also facilitated and residents engaged with the welfare department in relation to their individual cases.

25. E-wing was different in size and regime. As it was smaller, the care afforded to residents was more personalised in terms of staffing numbers to residents. Where required, assessment of residents' health was easier to complete and there was a greater focus on resolving issues and individual concerns.

26. The criteria that needed to be satisfied for a move to E-wing would depend on individual resident requirements and the initial reason why they had been placed on E-wing in the first instance.

27. If I was DD on a particular day and the decision to remove a resident to E-wing required my approval, I would be involved in authorising the removal. It may be that this decision was guided by Healthcare, or the resident may be moved to E-wing proactively ahead of a flight. In some cases, a planned flight would be cancelled, so the resident could return to a normal wing (this may not require my approval). Each decision was based on the individual's needs.

28. E-wing was used for residents on both the Rule 40 and Rule 42 regimes, in the event that the CSU was full. Sometimes both E-wing and the CSU were full,

whereas at other times, there may be no residents housed on either unit.

29. I do not have sight of the Rule 40 document associated with D2830, so I cannot comment on the evidence, reasons or justification for the use of the Rule 40 regime in this case. I recall that there had possibly been an altercation with another detained person, and that the detained person was displaying aggressive and threatening behaviour. He had been instructed not to take a can of red bull by officers in the wing office (as it was not his), and he was causing disruption to other detained persons on the wing. Whilst being moved to Rule 40, the detained person attempted to evade officers. Had this not happened, I imagine that I would have visited D2830 and de-escalated him from Rule 40 and returned him to E-wing.

30. I engaged with detained persons in an open, respectful and honest manner. I would always say that I would be honest with them, even if the news I was delivering would not be received well. I utilised translation services in the form of Big Word on a regular basis, to ensure that residents clearly understood what I was saying. Although interpreters were easily accessible, some language interpreters were more difficult to access and there may be a delay in reaching them. This sometimes meant that I would have to wait, or reconvene a meeting until a translator could be accessed.

31. I was not based at Brook House but I completed a weekly rostered DD shift. This occurred once per week, with on-call duties overnight. Every six weeks I performed the DD role over the weekend, which commenced at 08.00 hours on Friday morning and finished at 08.00 hours on Monday morning. I attended site on the Friday, Saturday and Sunday between the hours of 08.00 and 17.00, and visited both sites. I ensured that I visited every area of Brook House and completed any reviews that were due, whether that be Rule 40, or ACDT constant supervisions. I was on-call outside of these hours and contactable via mobile phone and laptop. As part of this role I visited every area of Brook

House, engaging with staff and residents, completing the above reviews and dealing with incidents should they arise. I would also ensure that all paperwork relating to any incident was completed and submitted to the relevant agencies within specific timescales. I occasionally covered more than one DD shift during a week, for example, when a colleague had booked annual leave.

32. There were financial pressures placed on G4S and I believe that this had an impact on staffing numbers. In my role as DD, a balance had to be struck between providing a contractually compliant service and being able to deliver care in an emergency situation, for example, where a resident required treatment in hospital. Pressure was also applied by the financial implications (in terms of performance points being applied) for failing to provide an escort.

33. I was made aware of alleged racist attitudes and behaviours amongst the staff group, but I do not recall witnessing any behaviour of this type myself. Whilst I do not recall the behaviour allegedly exhibited, or the outcome of any investigations, I remember that DCO Luke Instone-Brewer and DCO Babtunde Fagbo allegedly behaved in what could be deemed as a racist manner towards residents.

34. With regard to homophobic and / or misogynistic attitudes or behaviours, I am aware of an incident involving a member of the SMT (Juls Williams) and DCM Ellie Sewell where a banana was pushed into her face and a comment was made. I do not recall the exact comment made and was not a witness to this incident. I am aware that it was investigated, but do not know the outcome of the investigation.

35. I was not personally aware of any staff bringing drugs into Brook House. I was aware that there were suspicions around several staff, but I was not provided specific details as this was dealt with by the Security Department and was confidential. I am not aware of any member of staff being discovered bringing

drugs into Brook House.

36. I experienced a form of what I would describe as bullying by another member of the SMT (Neil Davies). Neil Davies was Head of Security at the time. I reported it to my line manager (Stacie Dean) and she escalated this to the Centre Director, Ben Saunders. She also chased the matter on a few occasions for an outcome. I am aware that Neil Davies subsequently resigned with immediate effect when he became the subject of an investigation, as several other members of staff had also complained.

37. Neil Davies was abrupt and dictatorial. He would tell me to do something and when I asked a question about what he asked (as I was attempting to gain more knowledge), the response was often 'because I am telling you, just do it'. This happened on several occasions and staff commented on how he spoke to me. He was witnessed shouting and behaving in this manner towards me.

38. I recall two occasions where I investigated / dealt with allegations of bullying. One occasion involved DCM David Killick and related to several staff who made allegations about him. The investigation was protracted and took place over an extended period. This was because initially there was only one complainant, but when interviewed she named several witnesses. When we spoke to each witness individually, several of them made allegations about David Killick, which all had to be dealt with. I was advised by Steve Skitt that these should form part of the same investigation. It was also protracted due to the terms of reference set by Steve Skitt and the need for consistent note taking, coupled with sickness absence and annual leave. The advice given to me was that there needed to be consistency. Therefore, I was to continue with the interviews when the original note taker (who I believe was Emma Picknell) went off sick.

39. The second bullying investigation I dealt with involved DCO Shayne Munroe

and DCO Bonnie Spark. I cannot recall the exact details of the investigation, but I do recall that DCO Shayne Munroe was temporarily transferred to Tinsley House whilst the investigation was ongoing. From memory, I believe the bullying related to name calling and the way in which each DCO spoke to one another, but I cannot remember the details with any certainty. I recall that the outcome was that DCO Shayne Munroe received a disciplinary for using inappropriate language.

The SMT

40. SMT meetings were held monthly, although on a few occasions I recall them being cancelled or rescheduled due to operational reasons. At the meetings we discussed the performance of various areas, improvements, action points from previous months, any areas of concern / risk and any other business. The meetings were beneficial from an update perspective and provided an opportunity to discuss any concerns or issues that may have arisen during the previous reporting month. However, there were some issues with updates and action points being completed in certain areas that were left and often rolled over several months. This could be frustrating, particularly when other areas were working to ensure outcomes, consistency and contract delivery.

41. I recall raising one issue regarding the allocation of line managers to officers, when it became apparent that some staff were unaware who their direct line manager was. Staff had also graduated from their initial training course ("**ITC**") without being assigned a line manager, which I felt did not assist their integration into the Gatwick team. In particular, I felt that it impacted upon their ongoing development, the EDR process and that it meant that new staff did not have a point of contact to discuss any issues that they may be experiencing.

42. I recall that it was decided that line managers would be assigned as part of the ITC process, and that the designated line managers would introduce themselves

to their direct reports on the ITC. This assisted with their initial mentoring / shadowing period. Staff who had already graduated from an ITC but had no line manager were to be assigned one and the same process was to occur.

43. I believe that SMT meetings were contractually required to take place every month. My recollection is that this did occur most months, but there were occasions when they were either cancelled or rescheduled due to other business needs or commitments. In my opinion, some of the meetings were beneficial and provided the Head of Function an opportunity to give an overview of each area and its performance. The action points from the previous meeting were also discussed and updated. However, there were occasions where updates were not given, leading to them being left as an agenda item for the following month. Financial details were discussed and updates provided on profit / loss, balance sheets and other expenditure by the accountant, Kalpesh Mistry. Upcoming or future projects were discussed together with any other business.

44. Generally, use of force ("**UOF**") incidents were not discussed or reviewed during SMT meetings. These discussions formed part of a separate meeting, although during the Relevant Period they did not occur regularly.

45. In the event that a UOF needed to be reviewed, then it may be raised at the SMT meetings or could be discussed in the morning meeting. Regular UOF meetings were introduced in May / June 2018 and these were completed monthly.

46. The leadership of senior managers at Brook House encouraged us to be open, honest, work as a team and provide a high level of care to detained persons. In my opinion, the SMT often felt disjointed and did not always work cohesively. Being based at Tinsley House meant that I sometimes felt 'out of the loop'. However, I knew who I could turn to or rely on for support and I knew those who would assist during incidents to achieve a successful resolution. I felt that an open-door policy was promoted by all of the SMT and this in my opinion,

was the case. However, sometimes the communication was lacking and mixed messages were received, which had a detrimental effect on leadership.

47. I cannot recall any changes after the visit from Jerry Petherick in October 2014. I cannot recall any changes to the management structure.

48. I have reviewed document CJS0073632 and it is the first time that I have seen it. I was unaware of a grievance submitted regarding temporary promotion and I was unaware of the details contained within this grievance. However, I am aware that Stacie Dean had submitted a grievance after a period of sick leave. If I recall correctly, she did not return to the immigration removal centres ("**IRCs**") at Gatwick. I can confirm that in my role as E1 Operations & Residential Manager at Tinsley House (and with my line manager, Stacie Dean), we discussed how Tinsley House would operate during the period of closure for refurbishment. There was a focus on staff training, contingency plan updates, use of annual leave and allocation of core security staff. This proposal and action plan was discussed with Ben Saunders and agreed. Staffing numbers were low at Tinsley House due to staff members resigning and leaving. This was partly due to contract issues and 'clumsiness' in communicating changes to contracts. These issues primarily related to staff who were on contracts that stated that they would be based at Tinsley House, being given contracts stating Gatwick IRCs, thus enabling cross-deployment.

49. I can confirm that DCM Brackenridge was temporarily promoted into an E1 position to manage the on-site building refurbishment, without an advert or interview process (something I had to do when I was both seconded and then substantiated in my E1 position). This upset a number of staff who said they would have applied had they known about the role.

50. I attended a couple of Trading Reviews as part of my development, where financial elements of the contract and possible profit margins were discussed.

However, I was not privy to the figures. I recall that the Home Office requested cost savings, but I would not have been privy to the details of this.

51. I am aware that there was an issue with the disclosure of some confidential medical information, but I do not recall the exact details.

52. I am unable to confirm the outcome of the matter relating to Stacie Dean. I believe that she went on long term sick leave and did not return to the Gatwick IRCs.

53. I had a mixed experience working with other senior managers. I found a percentage of the senior managers I worked alongside incredibly supportive and helpful. We worked towards achieving the same goals and had the same level of commitment and respect. However, I feel that other senior managers viewed their role as a job. They appeared detached and uninterested. If at any time there was an incident and I was performing the role of DD, I knew who I could rely on to provide support and remain on site to ensure a successful resolution. I also knew of other team members who would leave me and go home, due to it not being their DD shift. There were members of the SMT that I could go to for advice and also those who I could not.

54. I feel that I had a good working relationship with the Home Office. My contact with the Home Office was during DD shifts and outside of this, in relation to contractual matters and my areas of responsibility. I had a good working relationship with Michelle Smith and Debbie Weston. I worked closely alongside Debbie Weston at Tinsley House in relation to contract delivery and Her Majesty's Chief Inspector of Prisons' ("**HMIP**") work. I worked with Michelle Smith in similar circumstances, but more so around certain projects that I was involved in at the time, for example, the design for a Care Suite at Brook House. I always ensured that when I was on shift at Tinsley House or completing my rostered DD shift at Brook House, I would say 'hello' to Home

Office staff. I worked regularly alongside Janina Carman, Heenaxi Patel and Jenny Van Den Burgh.

55. The Home Office would on occasion attend ACDT constant supervision reviews, or provide an update on the detained person's case. The case manager or DCM completing the case review would ensure that the relevant multi-disciplinary team were present, whilst the DD would chair the meeting. This was a G4S specific directive.

Staffing

56. In my opinion, the staffing levels at Brook House were inadequate to enable staff to perform all of the functions of their role. There are three landings that should be patrolled on each residential wing and a wing office that should be staffed at specific times. Therefore, if a contract states that at least two DCOs should be on duty throughout the day, this means that these areas are not always covered. As a collective group, the SMT raised the issue with the Centre Director and part of our duties was to ensure adequate staffing levels when we were performing the role of DD. I would endeavour to ensure that staffing was appropriate when I was DD and if an incident took place (which meant that staff had to work late), I would look at staffing levels for the next day, so that the regime within the Centre could be maintained. I did not witness the impact that the staffing levels had daily, as I was based at Tinsley House. However, I was aware of the impact when performing the role of DD.

57. The issue of staffing levels was always high on the agenda in terms of DCOs, DCMs and specific members of the SMT raising their concerns. Concerns raised were about staff being tired, morale being low, staff sickness escalating, the impact this had on the Centre and its operation, and the welfare needs of residents.

58. In my opinion, the activities and services required under the contract were, for the most part, provided. On occasion, there may have been some failures, for which performance points would have been awarded, or mitigation requested. The role of the DD is to ensure that service delivery is upheld and if there were staff shortages due to sickness etc., it would be the role of the DD to manage the contractual delivery and care of detained persons accordingly. For example, if there was an emergency escort for a detained person scheduled, ensuring that this took place to limit any detrimental effect on the detained person's wellbeing.

59. Staffing shortages led to low morale, increased sickness / absence, loss of enthusiasm to deliver the contract, increased 'attitudes' towards one another, and a perceived potential impact on the safety and security of the Centre. However, I did not witness any negative impact on resident welfare that I can recall.

60. Some staff were reluctant to cross deploy from Tinsley House to Brook House. In my opinion, some staff who had been at Tinsley House for several years felt that the environment at Brook House was not what they were accustomed too, in terms of building design, regime, stricter rules and regulations. Some Tinsley House staff stated that they felt nervous and that when they had assisted at Brook House, they were not given any shadowing or explanation of the regime, rules and requirements of the area they were rostered to work in. They often found themselves alone on residential wings. In my opinion, previous contract negotiations had taken place in a 'clumsy' manner with staff who had Tinsley House contracts prior to Brook House opening.

61. I cannot comment on whether conscious decisions were made to maintain staffing levels below contractual requirements in order to provide cost savings. Although staffing levels were low and cost savings were requested, I was not aware of the specific details, proposals or outcomes.

62. Brook House suffered with issues relating to the retention of staff. Staff often

left due to being offered different employment with better salaries and a better work life balance. Gatwick airport is located close to Brook House and the airport was / still is a major employer in the area. Shift patterns, working hours and salary were all cited as reasons for leaving. The majority of staff who left were DCOs. I recall that a higher percentage were residential wing based staff from Tinsley House.

63. I reviewed staff exit interviews. Where feasible and within my remit, Stacie Dean and I would implement changes to assist our staffing group, raise morale and improve retention rates. This would be in terms of working conditions, knowledge within the DCM group, annual leave etc. We operated an open-door policy and staff could come and speak with us on a personal / private level if they needed to. The staffing numbers and shift patterns were dictated by the contract, but we were flexible with people's needs and tried to accommodate where possible, without detriment to service delivery. Individual issues with specific managers would be addressed on a one-to-one basis, or as part of the EDR process, depending on the nature of the issue.

64. Document CJS005291 refers to an incident that took place during a night shift. I was not the DD during this shift. My role was to read Security Information Reports ("**SIRs**") submitted from previous shifts and make comments or raise concerns. A welfare check should have been completed on the DCO involved when they were next on shift by the Oscar 1. This was requested, although I cannot comment on whether this took place.

65. I noted that an investigation should, in my opinion, take place to ascertain what happened, why the detained person was not placed on Rule 40 for assault and what the police investigation outcome was. The information relating to this should / would have been fed back to the security department, from the comments I made on the SIR.

66. The security team would have followed up with any police investigation.

UOF

67. I cannot recall having any concerns about a UOF incident. An incident I was involved in was referred to the Professional Standards Unit ("**PSU**") for investigation. I was interviewed on 29 August 2017 and findings were provided.

68. I was at one point instructed by Neil Davies, the then Head of Security, to oversee a UOF taking a detained person's fingerprints by force at Tinsley House. As far as I am aware, this was the first time that force had been used for this. The outcome was successful with no injuries to the detained person or staff. It was reviewed due to the nature of the UOF. I believe that a control and restraint ("**C&R**") instructor was in attendance and I recall seeking advice and clarification from Her Majesty's Prison and Probation Service instructors at Kidlington.

69. My opinion of the use of C&R techniques was largely based on my position at Tinsley House, where it was not used regularly. In my opinion, during my role as DD at Brook House, C&R was not used excessively. Had I felt that it was being used excessively, I would have escalated the issue and ensured that the incident was thoroughly reviewed. In my seconded role as Head of Safeguarding I implemented monthly UOF meetings and ensured that all UOF incidents were reviewed with the UOF Co-ordinator, DD who was on shift at the time of the incident and the Home Office. This was a HMIP recommendation and I also believe that it formed part of the Kate Lampard Inquiry.

70. My role in the suspension of Lia Winston was as a nominated point of contact, to provide support to Lia whilst she was suspended. I had contact with Lia once per week to be a point of contact for her in the event that she had any questions. I also provided details of support that she could receive from the Employee

Assistance Programme. I would not be able to provide updates on the investigation or information contained within it, as the investigation would be completed by the staff member noted in the terms of reference.

71. I was issued terms of reference to investigate the allegations that had been made about Dave Killick. I utilised a standard method of investigation used by G4S and reported on my findings, paying particular attention to the points noted in the terms of reference. I am unable to comment on document CJS0072840 as I have not been provided access to it.

72. It was a protracted investigation for the reasons noted earlier in this statement. I followed the instructions I was given to complete the investigation and raised any issues I had accordingly with Steve Skitt. I recall my recommendation was that disciplinary action should be taken. I submitted my report to Steve Skitt, who I believe dealt with the outcome. I do not recall what the outcome was or when it was concluded.

73. In my opinion, there was not widespread bullying amongst members of staff. I was aware of a few incidents / allegations of this nature, but to the best of my ability, I recall that they were investigated.

74. The SMT promoted the use of whistle-blower hotlines / Speak Out and encouraged staff to be open and honest and report any allegations of this nature, so that they could be dealt with appropriately or investigated.

75. Staff were encouraged to speak to line managers about such issues and escalate if they felt it was appropriate to do so.

76. In my opinion, there was not a culture of raising grievances against colleagues. I believe that some grievances were raised when issues that had been reported had not received successful outcomes, or staff felt that the outcomes were

dissatisfactory.

Incident on 25 April 2017 – D1527

77. My involvement with D1527 would have been through my role as DD. On 25 April 2017, I completed an ACDT constant supervision review as chair of the meeting. I believe this to be the only case review I chaired with this detained person.

78. I believe that D1527 was on a Rule 40 regime at the time, together with an ACDT constant supervision. Therefore, he would have been located in one of the care rooms on E-wing (either E007 or E008). I cannot recall why D1527 was on a Rule 40 regime, but D1527 would have had access to fresh air / exercise, showers and would have taken meals in his room. D1527 would have been with an officer at all times due to his constant supervision. This was the reason why he was on E-wing as opposed to the CSU. The Rule 40 regime is stated in the DSO.

79. I am unaware / cannot recall whether I was on site for the two UOF incidents. One set of documents I have reviewed shows the UOF took place at 19.09 hours. My DD shifts were usually between the hours of 08.00 and 17.00. Therefore, I may have been notified as per on-call arrangements, being phoned on my company mobile by the Oscar 1 on shift (this is noted as being at 19.40 hours on the DCF2 form). Unless there were other circumstances / operational issues, I imagine that I was not on site, although I cannot recall for sure.

80. The procedure for notifying me of a UOF is to contact me if I am on site, either in person or via the telephone, and to note the time communicated on the DCF2 form. If I am off-site, staff could contact me via on-call arrangements and my company mobile. This applies throughout night shifts and should be completed as close to the time that the force was used as is practicable.

81. I would ensure that the detained person was seen and assessed by Healthcare and that constant observations were performed on any detained person who had been subject to a UOF. In a circumstance where Healthcare advised that a detained person needed hospital treatment, an escort would be arranged in a timely fashion. Depending on the nature and circumstances of the UOF and if I was on site, I may visit the detained person.

82. In my opinion, it would have been possible for a DCO to contact me if they did not feel comfortable with the DCM in charge. The only exception would be if I was in a meeting, but I would respond after the meeting had finished. Had the DCO wished to speak with me, I would have found a suitable place in which to do this, as when I was working at Brook House I based myself in the admin area, which was an open space and not private.

Incidents on 30 June 2017

83. I was DD on 30 June 2017. A previous instruction had been sent stating that DDs were to attend any planned interventions if on site, or ensure attendance if possible. I remember this incident being protracted and involving numerous members of staff, due to the size of the detained person and level of aggression and threat displayed towards staff. I recall a PSU investigation was completed on 29 August 2017 and a review of the incident was completed.

84. There would have been a de-brief (that would have been filmed) after the incident where officers could state how they felt the incident went and was managed. At this point, their efforts would have been commended.

85. The incident would have been discussed in the morning meeting the following day, with reference to the efforts of the officers. Team of the Month recommendations might also be submitted. I would have spoken with all of the

officers involved and commended them on how they worked as a team, and the effort they had shown in a challenging and protracted situation. I believe the Director personally thanked all of the staff involved.

The Panorama Programme

86. I was horrified, shocked and disgusted at what I saw on the programme. I was disgusted at the actions of some staff and felt saddened that I was associated with this.

87. Following the broadcast of the programme, scrutiny increased. A new interim director was brought in and there was an increased focus on daily tasks and outcomes. I feel that there was a greater focus on the wellbeing and care of detained persons and that staffing level measures were implemented to aid this. I felt that communication increased and became clearer and that the SMT worked far more cohesively. I was seconded into the Head of Safeguarding role in May 2018 and was then based at Brook House.

88. The Lampard Report was produced which provided a document to work to. This enabled the SMT to address specific issues, namely staffing levels, and meant that change was brought about in a focussed manner.

Any other concerns

89. I do not consider that there are any additional matters which relate to the culture of G4S at Brook House, or the treatment of detained persons which may be relevant to the Inquiry. In my opinion, the length of detention experienced by some detained persons is excessive and detrimental to their wellbeing, but this is ultimately a Home Office decision, rather than something which can be controlled by staff at Brook House.

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	Sara Edwards
Signature	**Signature**
Date	1/3/22