Brook House Inquiry

First Witness Statement of Sarah Bromley

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 21 December 2021.

I, Sarah Bromley, of DPA will say as follows:

Introduction

1. I work as the National Medical Director for Health in Justice for Practice Plus Group. My role covers oversight and governance of the quality of healthcare provision in our services across England, including IRC Gatwick.

2. I have visited IRC Gatwick on three occasions, once prior to the start of our contract on 1st September 2021 to speak with the governing team and the senior leadership of the healthcare service during mobilisation and twice between 1st September and 31 January. One of these visits was with a team to assess the clinical quality and systems/process in place at IRC Gatwick. My third visit was to understand the service in more depth. During this third visit I spoke with multiple members of staff, observed a planned removal and shadowed a GP in clinic.

3. I have read the Rule 9 request for a witness statement from PPG. I am able to address some of these requests: I understand that the other requests are being addressed by my colleague Mr Luke Wells. I have used the same headings as the Rule 9 request.

Training of Health Services Staff

Rules 34 and 35 PPG Local Process

4. Rule 34 is clear that all residents have a right to an assessment by a doctor within 24 hours of arrival. As part of the orientation training and induction for all staff they are made aware of the Detention Centre Rules and therefore the importance of Rule 34.

5. PPG have developed bespoke reception screening training for teams assessing and looking after people as they arrive in secure settings. This was originally devised for the prison setting and has just completed its first pilot, but we intend to adapt the course to improve the quality of reception screening into the Immigration Removal Centre setting. Recognising that attendance at Rule 34 appointments is low with a high rate of DNAs (Did Not Attends), PPG plan to train staff in the importance of the initial reception screen, talking to people about the purpose and importance of the Rule 34 appointment and encouraging them to attend. Our intention is to have this developed and ready for staff to undertake by the end of May 2022.

6. Currently the reception screening course content is as follows:
   - **AIM** – To be competent and confident in Practice Plus Group's Reception Screening
   - **Outcomes:**
     - Support each new reception with a person-centred approach
     - Discover the importance of patient information and where to find it.
     - Build a positive patient / clinician relationship
     - Distinguish different styles of communication
     - Maximising communication to obtain information in the right way
     - Consider health literacy
     - Identify behaviours of non-engagement and non-compliance
     - Recognise signs and symptoms of withdrawal
     - Discuss what to do following the screening templates
     - Assess risk factors effectively
     - Prioritise clinical judgment
     - Determine correct escalation and referral procedures

7. Staff are made aware of the process for obtaining Rule 35 assessments during induction and how to refer if the patient asks for a Rule 35 assessment.

8. Our reception screen course described above will also train staff in the identification of conditions that may be detrimentally affected by detention and therefore require assessment under Rule 35. This will enable a more proactive approach to identifying patients who may be at risk due to detention.

AAR and DSO Adults at Risk in Detention

9. Our current induction process includes introduction to DSO – Adults at Risk in Detention. Staff will be asked to sit in on the weekly vulnerable persons meeting where all the Adults at Risk are discussed enabling an understanding of the process.

Safeguarding

10. All patient-facing healthcare staff are trained to Level 3 safeguarding for both Adults and Children in accordance with our Safeguarding Policy. This consists of two on-line modules (one for adults and one for children) followed up by two half day training sessions, either virtual or face-to-face, again one for adults and one for children.

11. The safeguarding lead on site is trained to Level 4 and able to support robust safeguarding processes on site. The Level 4 training consists of two full days of training.

Constant supervision

12. All constant supervisions are undertaken by officers and not healthcare staff. All healthcare staff are given training in ACDT within the initial partnership training from Serco.

13. Our constant supervision policy requires that all detainees placed on constant supervision undergo a Mental Health Assessment to ensure we understand and meet Mental Health needs. Our aim is that constant supervision is used for the shortest possible time to manage risk due to the intrusive nature of constant supervision. There are various escalation points identified to ensure that the risks associated with both reducing or continuing constant supervision are effectively managed. This is done via our multidisciplinary team meeting.

Mental health model slides, DSO Mental Vulnerability in Detention, and Mental vulnerability

14. Staff are provided with links to the DSOs for review.

15. As part of the service development plan, mental health training will take place as part of the roll out of the Mental Health Standard Operating Procedure (MH SOP) and the 'Making Sense' psychological therapies programmes. This training will include trauma informed practice, expectations of the Mental Health service contained with the MH SOP and an introduction to the Making Sense programme.

16. Bespoke secure environment Mental Health Assessment training has been developed and piloted in Yorkshire and once evaluated will be rolled out across all our establishments.

Food and fluids refusal

17. Food refusal is discussed as part of staff induction. Staff will be directed to both the DSO and PPG Food Refusal policy [PPG000032].

18. If there are any changes to the DSO, this is discussed at staff meetings and followed up by an email to all staff notifying them of any changes.

19. PPG's Food Refusal policy sets out clearly the expectations of the clinical management of patients who refuse food, including the assessment of mental capacity, physical health monitoring, and escalation to senior clinicians.

Use of Restraint

20. Healthcare staff are required to undertake SPEAR (Spontaneous Protection Enabling Accelerated Response) training which is run by Serco staff. There are limited spaces on these courses and we are working together to get all staff covered. Healthcare staff are not trained in Use of Force: however, they are allowed to attend the refresher training given to officers to observe and see what the response from Healthcare staff should be. Healthcare also attend a monthly Use of Force (UOF) meeting and this is attended by a management member and a clinical staff member. During this meeting all UOF incidents in the previous month are reviewed including viewing the video footage of one or two cases.

Substance misuse

21. The Drug and Alcohol strategy currently in use is owned by Serco. Since the transfer to Serco there have not been any Drug Strategy meetings. PPG have requested a Drug strategy

meeting to enable a collaborative approach to the management of Drug Use in the IRC. The first meeting took place on 31 January 2022 and is planned to be a monthly meeting.

22. We understand that at present 2 doctors have completed part 2 of the RCGP Certificate in the Management of Substance Misuse and one doctor has undertaken part 1. We will work with our GP provider (Dr PA) to increase the number of GPs who have undertaken this training and also ensure that nursing staff have undertaken at least part 1 of the RCGP Certificate in the Management of Substance Misuse.

R40/42 assessment template

23. The Rule 40/42 assessment template is a Home Office document. During healthcare orientation, staff are shown this form and attend a Rule 40/42 review. Whilst there is no formal training in this, familiarity with this template is part of the induction process and is signed off as part of their induction competency list.

Instructions provided to PPG staff

24. All staff must complete their induction programme. New healthcare staff attend a partnership training run by Serco; this includes training on Security (including Imbalance, Keys and doors, and Personal security), Health and Safety, and ACDT training. They are also required to complete two online training sessions on self-harm and suicidal thoughts. No keys will be issued to staff unless they have completed this training.

25. PPG provides a range of on-line Mandatory training modules which are required to be completed within the first 3 months, as well as the induction set out in the induction section.

26. PPG has worked with Stafford University to develop a two-day training module to support staff new to providing healthcare in secure and detained settings. Our intention is to work with the University to develop a more bespoke version of this course for staff working in immigration removal settings (rather than prisons) and will utilise learning from the first 6 months of this contract to identify current gaps in training and induction that the course can meet. This will include training in relevant DSO rules of detention

27. Safeguarding training clearly outlines responsibilities of all staff in relation to welfare of individuals located at any of the sites to which provide healthcare. The training uses the '4

Rs' (Recognise, Respond, Record, Refer) to systematically ensure learning outcomes are met and is in line with:

- The Intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018)
- Skills for Care and Health: Core Competencies for Health Care support workers and Adult Social Care workers in England DOH 2015 (NHS England)

Clinical staff undertake Safeguarding training to Level 3 every 3 years and non-clinical staff undertake Level 2 training every 2 years. The course outline for Level 3 training is attached as **Exhibit SBA.**

28. Our PPG training manager deals with multiple training organisations who work with us to develop bespoke training for secure and detained settings. Examples of this include (but are not limited to) the university course noted above, suicide awareness training (ASIST), Mental Health Assessment training, Use of Force and Healthcare responsibilities in Control and Restraint, Reception Screening training and ILS (Immediate Life Support). We have plans to develop training in Rule 34/35 for the doctors to ensure high quality assessments, and will work with the team at IRC Gatwick to identify other training needs specific to the environment and source organisations that will work with us to develop appropriate and relevant training.

29. In addition to this we will undertake a training needs analysis to identify other health training required, for example the management of long-term conditions, delivery of the Making Sense psychological therapies group, and substance misuse management courses.

30. Serco will be running yearly refreshers for staff on ACDT. Any reviews of any DSO are sent to staff so they are aware of any changes.

<u>Training in the management of detained persons' welfare</u>

31. There is no specific training on management of detained persons welfare: however, this would be covered in the training on safeguarding, equality and diversity, and Prevent (which also looks at radicalisation) training.

Refresher training

32. There is no specific refresher training in the management of detained persons but staff are expected to undertake mandatory training each year. Staff will also engage with an annual appraisal which will identify personal development needs, including training. In addition to this every member of staff will be offered clinical supervision, providing an opportunity to reflect on their clinical care and identify areas for improvement or development.

Training in the use of force/control and restraint ('C&R')

33. PPG are currently piloting a training package (**Exhibit SB2**) specifically related to clinical assessment during and following C&R. Gatwick has been named as a priority site once this has been evaluated and ready for roll out.

Training for 'Control and Restraint', 'Use of Force' and 'Minimising and Managing Physical Restraint' (MMPR)

34. Healthcare staff are not trained in C&R, UoF or MMPR but are offered SPEAR training as discussed above.

Training in Rule 34 assessments and Rule 35 reports

35. As above, there is no specific training for Rule 34.

36. Rule 35 training was previously provided by the Home Office and NHS England but this has not been offered over recent years.

37. Currently Dr PA, our GP partner, provide new GPs with a slide set about the Rule 35 process and an example of a 'good' rule 35 submission. This is discussed with the GP to ensure understanding of the process in place.

38. As noted above our intent is to develop a bespoke Rule 34 and 35 training package which will be ready for delivery by 1st July 2022 and will be delivered both as part of induction of new GPs and as a refresher on an annual basis.

Training in the management of individuals at risk of self-harm or suicide and the ACDT process

39. This training is provided by SERCO to all our staff.

40. I understand that all our staff have received this training and any new starters will access this within their induction.

Training in the Adults at Risk Policy and Statutory Guidance

41. There is currently no specific training for this provided. We ensure staff are fully aware of this policy and attend a vulnerable persons meeting (held weekly) within their orientation.

Training in the management of individuals with substance misuse issues.

42. Please see above for the current situation regarding the training of GPs in clinical substance misuse and our future plans.

43. Our approach requires that all clinicians involved in the management of patients with substance misuse needs undertake the Royal College of General Practitioners Certificate in the Management of Substance Misuse Part 1 training.[1] In addition, GPs or Non-Medical Prescribers undertaking responsibility for prescribing Opioid Substitution Therapy prescribing will complete Part 2 of the above course.

44. Psychosocial workers will have access to a range of training options to be identified by the training needs analysis noted earlier.

45. Formal Substance misuse training is yet to take place since PPG took over the contract at Brook House.

46. Our in-house Psychosocial Substance Misuse staff are able to provide informal training in substance misuse for the wider healthcare team.

Training for other members of staff at Brook House

47. The Head of Healthcare provides an induction into Healthcare for new officers. The psychosocial team also provide training to the new officers on substance misuse. This is yet to be reviewed by PPG.

48. Our intention is to develop a trauma informed training package for all staff in Gatwick IRC to ensure awareness of the prevalence and impact of trauma on detainees and provide some

[1] www.sldtraining.co.uk/courses

understanding of how the service can work compassionately with people who have experienced trauma and reduce the risk of 'accidental' re-traumatisation.

Oversight

Clinical audits

49. Clinical audits are carried out in line with the national PPG audit schedule, submitted on the 27th of each month. The National PPG audit schedule includes a series of audits over a 12 month cycle assessing compliance with standards across a number of areas including:

- PROTECT audits: a series of audits designed to assess activity relating to lessons learned from Deaths in Custody and Significant Incidents. This includes audit measures regarding Patient Screening (reception), Record Keeping (documentation), Ongoing Medication (continuity of medicines), Take ACCTion (healthcare involvement in ACDT processes), Emergency Care, Continuity of Information, and Tackle Abnormalities (identifying deteriorating patients);
- Infection Prevention and Control audits, including Hand Hygiene, Cleaning and Decontamination, Sharps Handling and Disposal, Outbreak Management, Aseptic techniques, Venepuncture, and a COVID safe workplace inspection;
- Medicines Management audits including CD Management, Errors and Incidents, Responsibilities and Prescribing patterns, Medicines Administration, and Stock Control;
- Regular quarterly Safeguarding audits; and
- Other audits including Referrals, Patient Engagement, Blood Borne Virus management, NICE compliance, Information Governance and Security, HR records - 121s and PCRs.

50. The audits listed below were completed in November. The percentage quoted is the reported compliance with the standards in each audit. This is currently being reviewed by the regional governance management to ensure that the audits are being undertaken correctly given that this is a new process for the Gatwick team.

- PROTECT Take ACCTion (auditing healthcare involvement in ACDT processes) – 83%

- Medicines Management CDs – 97%
- Hand Hygiene – 88%
- Mental Health patient care – 100%

51. The following audits were completed in December:

- PROTECT Record Keeping – 100%
- PROTECT Lessons learned - 100%
- Safeguarding Compliance – 100%
- Mental Health patient care – 97%

52. The last clinical audit was carried out on 24 December 2021. This was for mental health patient care (97%). It identified 5 incidents of patients not being provided with a copy of their care plan, 2 incidents of a lack of care co-coordinator being allocated, and 1 inadequate risk assessment. Since that audit, a mental health lead has been appointed who is coordinating an MDT meeting for MH ensuing that all patients have care plans and are being reviewed appropriately. Our governance manager is currently working with the team to set up a standardised action tracker and any actions relating to audit will be added to this in due course.

53. A further 5 audits were due by 27 January 2022 and completed on time:

- PROTECT - Emergency Response – 89%
- COVID-19 Safe Workplace Inspection Re-Audit – 100%
- Patient Engagement Audit – 73%
- Sharps Handling & Disposal – 100%
- Mental Health Patient Care Audit – 80%

Adequacy of healthcare provision at Brook House

54. Since we took over the provision of healthcare services at Brook House, there has been a significant change in the level of service. Service development meetings have commenced to progress the service delivery plan which sets out PPG plans to further develop the service at Gatwick IRC.

55. We have introduced for an in-house dental triage service on site, although cannot currently undertake dental treatments due to lack of dental suite. There are on-going discussions between NHS England and the Home Office regarding the need for a dental suite to ensure that routine treatment can be provided, preventing further dental deterioration. We have attempted to bring a mobile dental unit on site in the interim, but this was not supported by Serco or the Home Office.

56. We have introduced physiotherapy and podiatry services.

57. With regard to the future, we have commenced service development meetings to progress the service delivery plan. Initially we are focusing on improving:

- *Blood born virus (BBV) screening*
- *Section 7a national screening and vaccination programmes*[2]
- *Long term condition (LTC) management*
- *Significant increase in mental health offering, including introduction of psychologist and asst. psychologists to support psychological interventions.*

Complaints

Detained persons

58. Complaint forms are available on each wing and in clinical areas. Once completed by a detainee, these forms are posted into the healthcare post box and collected by members of

[2] https://www.england.nhs.uk/commissioning/health-just/#public-health

our team. The complaints are then added to a tracker spreadsheet and allocated to an appropriate clinician for investigation.

59. We respond to verbal concerns as they arise (for example, concerns raised during a consultation or *ad hoc* on the wings) which may followed up as a complaint if the issue is not immediately resolved.

60. Officers may directly raise concerns on behalf of patients which will be responded to in the same way.

Family/friends of detained persons

61. Family members can contact the healthcare team via telephone or in writing via our functional email mailbox or letter.

62. Consent is sought prior to responding directly to a third party. If consent is obtained both the patient and the complainant will be sent a response. If consent is not obtained the investigation will still take place, with the response sent to the patient only.

NGOs

63. The process is as per family/friends of detained persons.

Members of the public

64. The process is as per family/friends of detained persons.

Internal investigations

65. At present all complaints submitted to PPG regarding healthcare are internally investigated resulting in a written response within 20 days.

66. Once our feedback policy and complaints process are fully embedded all detainees that express concern or make a complaint will be offered a face to face appointment to discuss their concerns and attempt to resolve them. If this does not result in a satisfactory conclusion for the detainee the concern/complaint will be investigated as a stage 1 complaint and the detainee (or 3rd party as noted above) will receive a written response outlining the investigation and offering an explanation, resolution or apology as appropriate. If this fails to result in a satisfactory solution then the complaint will be escalated to Stage 2 and will be

investigated by a member of the regional PPG Health in Justice team and review by the Medical Director or Director of Nursing and Quality.

The circumstances in which complaints are passed to the Home Office/PSU for investigation

67. Where concerns relate to security or where there may be a risk to safety of a patient, information may need to be shared with the centre or the Home Office. This is particularly relevant to detainees subject to safeguarding arrangements or adults at risk.

Recommendations made following an internal or PSU investigation

68. Themes arising from a review of complaints are shared at Local Quality Assurance (QA) Meetings and shared with the wider healthcare team locally as well as via regional QA meetings. Learning from complaints will be shared via learning bulletins cascaded to all staff.

69. If there are significant concerns arising from a complaint this will be escalated by the regional governance manager and a Clinical Case Review which will utilise a multidisciplinary team to review the care provided. If there are failures identified from this process an Internal Learning Review will be commissioned and the incident reported to NHSE as a Significant Incident.

Consent to investigation

70. Consent is not required in order to investigate a complaint but is required in order that we share any information with a third party. We are committed to investigating any complaint regardless of the method by which is received.

71. On receiving a complaint from a party other than a patient we will ensure that the patient is made aware by communicating with them and acknowledging the complaint.

Number and nature of complaints

72. On review it appears that currently all feedback has been logged as complaints. The feedback policy was reviewed with the site and the Regional Governance Manager but has not yet been embedded at site level. The Regional Manager and Regional Governance Manager will revisit the feedback policy.

73. Of the 13 complaints logged, there is a mixture of requests and concerns and not all should be considered stage 1 complaints. None of these complaints or concerns were substantiated.

74. Below is a summary of the number and types of complaints since PPG took over the contract. At present there is no discernible pattern or common themes to the complaints:

September	1 relating to pain management
October	1 request for paracetamol
November	7 – 3 related to appointment requests, 2 from one patient regarding an ongoing medical condition for which he was appropriately referred and 2 relating to COVID 19 results
December	3 – 1 related to high blood pressure, 1 relating to access to secondary care and 1 regarding access to MH services
January	1 relating to concerns about antibiotic allergy
Total	**13**

Investigations

75. All patients receive a written response to any complaint we receive. Unfortunately, due to the length of stay, some patients have left before a response has been provided to their complaint. This demonstrates the importance of embedding the feedback policy, to ensure face-to-face resolution within 5 days where possible.

Whistleblowing

76. PPG has a whistleblowing policy which has been shared with the team at IRC Gatwick with copies available in the main office and in staff areas. The process is publicised using posters to encourage staff to speak up and these have been given to site and I understand have been put up on notice boards in staff areas.

77. To the best of my knowledge there has not been any use of this process since PPG took over the service on 1 September 2021.

Medical Justice

78. PPG understand that Medical Justice are a charity who support residents whilst in detention. Medical Justice are able to email PPG to raise any concerns regarding detainees which we will investigate. Additionally, they can request medical records on behalf of the resident as long as signed consent for this is provided by the patient.

79. Our healthcare team will facilitate a face to face appointment and provide a room for an independent doctor provided by Medical Justice to meet with a detainee on request to support a medico-legal report (MLR). Medical Justice will send the MLR for our GPs to review.

80. Our understanding is that Medical Justice offers independent medical advice and assessments to immigration detainees and writes medico-legal reports (MLRs) which can be used to support asylum claims and letters outlining significant medical concerns. They can act as an advocate for the resident.

81. Since PPG took over the provision of healthcare at Gatwick IRC we have not had any contact from Medical Justice and therefore are unable to comment on whether it adequately fulfilled its objectives.

82. We have not encountered any difficulties at present and our aim is to build a healthy working relationship with Medical Justice. We understand that there have been difficulties in the past between healthcare and Medical Justice but have no direct experience of this.

83. We do understand that occasionally there are difficulties relating to the provision of rooms due to the limited space available to healthcare in IRC Gatwick.

84. Going forward, we envisage that potential issues may arise in relation to the availability of room space to support independent doctor reviews whilst at the same time providing healthcare provision. Additionally, there have been a number of COVID outbreaks in IRC Gatwick resulting in a necessary limitation on the number of external visitors allowed into site to reduce infection spread. We anticipate this pressure will ease as the current wave of infections reduces.

Illicit Drugs

Current drug and alcohol policy

85. All new arrivals into Gatwick IRC are screened with an alcohol audit and potentially Clinical Opiate Withdrawal Scale (COWS) score for those who identify as drug users. Any patients with alcohol and SMS concerns are referred to the GP.

86. New arrivals have symptomatic relief overnight, and the healthcare team have discussions with the Serco team around the appropriate location to support observations and monitoring of withdrawal. E wing has 2 dedicated SMS beds for this purpose. The psychosocial team also engage with new arrivals as well as receiving referrals. Out of hours prescribing and the delivery of urgent medicines is available should this be required.

87. Psychosocial Interventions could include:

- Workshops;
- 1:1 sessions for residents;
- Brief intervention;
- Harm reduction;
- Acupuncture; and
- Group talking therapies.

88. Health promotion materials are available and have been translated into multiple languages. Big word translation services are also available should further materials require translation.

89. The psychosocial team currently have a low case load and utilise their time to carry out health promotion regarding drugs and alcohol use with those arriving and due to leave the centre.

90. The PPG psychosocial team are an integral part of the drug and alcohol strategy team. We understand that these meetings were previously held monthly: however, this has not taken place since the start of our contract.

91. PPG have requested that the drug strategy meeting is reinstated. The first meeting took place on 31 January 2022. Our new Integrated Mental Health and Substance Misuse Lead will represent PPG at this meeting.

Steps taken to prevent use of illicit drugs

92. The steps PPG has taken to prevent the use of illicit drugs by detained individuals include:

- Health promotion;
- Supporting the site in drug strategy;
- Clinical and psychosocial interventions provided;
- Raising SIRs as concerns arise;
- Pharmacy technician led in-possession medicines compliance checks;
- In-possession risk assessments and medication compact
- Substance misuse patient compact.

Steps taken to obtain medical or other assistance

93. GPs manage needs for clinical interventions in line with NICE guidance.

94. The numbers of patients requiring Opioid Substitution Therapy (OST) is usually very low. Currently there are 2 patients requiring this treatment at Gatwick IRC.

95. Psychosocial intervention and health promotion information is available, as described above. The psychologist will also introduce psychological interventions that will be co-facilitated by assistant psychologists and psychosocial workers.

Use of Force

Arrangements for Planned Use of Force (UoF)

96. For all planned UoF, healthcare staff are invited to the briefing prior to UoF. They will have completed the Briefing form prior to attending so any issues relating to the health of the

detainee can be raised, ensuring that staff are aware of health risks. This briefing is recorded on camera by Serco staff.

97. Healthcare staff accompany detention staff throughout the planned UoF carrying the emergency bag. Following UoF, patients who have been subject to UoF are checked to ensure that there are no injuries or healthcare concerns. This is then documented on a F213 form and in SystmOne Medical Records.

Unplanned UoF

98. Healthcare staff will attend a first response following a call which they will have received over the radio. On arrival they will assess the patient for any injuries or health concerns.

99. As with planned UoF, a F213 form is completed and full documentation recorded within the patient's clinical notes.

De-escalation tactics

100. De-escalation is undertaken by Serco staff and is attempted before initiating use of force.

Debrief process following UoF

101. Healthcare staff attend all post-UoF debriefing and this is also recorded on camera by Serco.

102. The detained person has the opportunity to feedback their views at this debrief. This debrief is undertaken by Serco. If any health matters (for example, any injuries) occur, healthcare will document this on the F213 form and treat the injuries appropriately.

103. The Home Office review all UoF with Serco and address any complaints. If there are any questions, these are sent to the Professional Standards Unit (PSU) for investigation.

104. Any complaints from a healthcare perspective would be investigated by Serco. Any such concern will also be recorded on our Datix Incident Reporting system to ensure wider organisational oversight and follow up.

Relocation to the CSU after UoF

105. The decision regarding the relocation of detainees following UoF sits with Serco and the Home Office, and factors affecting this decision include the safety of the centre and other

residents. PPG staff involvement in the process is by providing a health and safety screen prior to locating detainees in CSU in line with detention centre rules 40/42, as well as DSO Removal from Association and Temporary Confinement.

106. Health safety screens take place on relocation to CSU and within the following 2 hours.

UoF relating to self-harming

107. PPG has very limited experience of UoF being used to prevent residents in Gatwick IRC from self-harming. In any event, healthcare would always be present and would be able to give advice at the time. In our view UoF would only be justified in extreme cases where the patients is at risk of serious injuries and/or lacks capacity. These are complex decisions and would be escalated within PPG for support and senior clinical advice.

F213 forms

108. F213 forms are completed following every UoF and are given to the Officer to complete the UoF packs. F213 forms are also scanned into the clinical record.

UoF Reviews

109. Serco review all UoF incidents with the Home Office within 24 hours of the incident.

110. PPG attend a Monthly UoF meeting to review incidents and identify any learning to improve process. Any concerns that have been raised are discussed at this meeting. If the concerns require urgent investigation, this would be passed on to the Head of Healthcare. No requests of this kind have been received by PPG to date.

111. Any learning lessons that come from the review meetings are shared in the monthly staff meeting and also an email is sent to all staff summarising learning points.

112. We encourage our teams to share any lessons learned from incidents to be captured in local quality assurance and fed into regional quality assurance to embed learning more widely within the organisation. Gatwick will also benefit where learning has been identified on other sites.

Vulnerability of Detained Individuals

113. The initial reception screening template (**Exhibit SB3**) seeks to support clinicians to identify vulnerabilities at first contact. Much of the reception screen is focused on risk management and identifying vulnerabilities. Any vulnerability identified triggers completion of a Support Living Plan (SLP). The initial reception screen is an IRC specific short template signed off specifically for IRCs. This is under review by our SystmOne Development Group and will be subject to further development and improvement.

114. Within our prison sites, a second reception screen (**Exhibit SB4**) takes place which provide further opportunities to identify healthcare concerns and vulnerabilities. It is acknowledged that reception can be a pressured time with large numbers of arrivals in a short period of time, often overnight. It is important that the first screen focuses on immediate risk but this can make it more difficult to identify other vulnerabilities.

115. Within the service delivery plan, PPG have committed to working with Serco to pilot second reception screens as a further opportunity to identify any needs not picked up at initial screen. This will also present an opportunity to identify any adult at risk, whose health may be detrimentally affected by detention, who may be suicidal, or who have a history of torture not identified at the first reception screen. This will allow for an early offer of and/or prioritisation of Rule 35 assessments and also ensure detainees are aware that they can access a Rule 34 medical assessment, increasing the attendance rate at these appointments.

116. If it is considered that safeguarding risks exist, a referral will be made to the safeguarding lead, and patient referred to the local multi-professional complex case clinic (MPCCC).

117. Any Individual identified at reception as vulnerable will have a SLP open and this is shared with Serco and held on the wing with the resident. It is open for all parties looking after him to enter comments and is not a healthcare only care plan. All residents on a SLP will be discussed on the weekly vulnerable persons meeting which is chaired by Serco and attended by Healthcare, the Home Office, IMB and the Home Office Caseworkers if required.

118. As noted above, a new system of secondary reception screening will be implemented as part of service development and then evaluated to assess effectiveness of the system in adequately identifying needs and vulnerabilities.

119. Each SLP is reviewed individually and the review dates are written as required. As a minimum they will be reviewed at the weekly vulnerable persons meeting. All reviews are undertaken by a multi-disciplinary team.

120. The MPCCC is a local weekly meeting, recently implemented, that takes place with contribution from our expanding clinical leadership team as well as clinical team members. Patients with complex needs are referred to MPCCC for multi professional input. It is likely that a patient with vulnerabilities will be referred to MPCCC to ensure wider awareness within the clinical team and promote joint care planning. The MPCCC discussions will focus on clinical needs and care planning for patients but will feed into the weekly vulnerable persons meeting to ensure that the full clinical picture is taken into account when considering a detainees ongoing fitness for detention.

121. MPCCC membership includes but is not limited to the following;

- GP;
- Psychiatrist;
- Psychologist and/or assistant psychologist;
- Psychosocial workers;
- Integrated mental health &substance misuse lead; and
- RGNs, RMNs, HCA

122. The vulnerable persons meeting membership includes the resident, Serco Officers, Residential manager, Healthcare, Home Office and any other relevant parties (ie welfare, activity team).

123. The MPCCC is a minuted meeting, with a clinical template (**Exhibit SB5**) being completed for each patient discussed to ensure a record of the meeting is recorded within their clinical notes.

124. The Supported Living Plan is a legal document which is owned by Serco. Healthcare will also document in the medical records they have attended a review and any relevant outcomes.

Communication with the Home Office

125. I attach as **Exhibit SB6** the *pro forma* Home Office form IS 91 RA Part C. A copy of this document is sent to the Home Office when it is opened by Oscar 1 (Serco Duty Manager) and also on closure of the document. The case workers may also be invited to the case review if required. Any changes will be documented on an IS 91 Part C form which is sent to Home Office and the caseworkers. This is also documented in the medical records.

Rule 35 reports

126. The number of Rule 35 reports that have been made under each sub-section of the rule from 1 September 2021 to date is set out in the table below:

	Rule 35 (1) Medical Condition	**Rule 35 (2) Suicidal Intention**	**Rule 35 (3) Torture**
September	0	0	26
October	0	0	21
November	0	0	23
December	1	0	24
January to date	0	0	5

127. It is difficult to ascertain the percentage of the total population of Brook House these figures represent during this period due to the changes in our population on a daily basis. I would estimate, however, that these figures represent approximately 20-25% of our population.

128. Some of the residents will have come from other centres where a Rule 35 has been undertaken before. In January, the number is low to date due to the site being in outbreak resulting in no new arrivals to the centre

129. Due to low numbers within the centre, the average waiting time for a detained person to see a GP for an assessment under Rule 35 has been two days. The report is sent to the Home

Office and if we have not had a response within two days we will chase the Home Office for a response.

130. The number of cases in which a Rule 35 report was obtained and led to a release of the detained person from detention is set out in the table below:

	Rule 35 (1) undertaken	**Maintained/ Released**	**Rule 35(2) undertaken**	**Maintained / released**	**Rule 35(3) undertaken**	**Maintained/ released/ no response[3]**
September	0	0/0	0	0/0	26	17/6/2
October	0	0/0	0	0/0	21	11/8/2
November	0	0/0	0	0/0	23	14/8/1
December	1	0/1	0	0/0	24	15/7/2
January to date	0	0/0	0	0/0	5	1/1/0 3 awaiting response

ACDT forms

131. The number of ACDT forms that have been opened on detained persons (including the numbers of detained persons to which these refer) is set out in the table below:

	Opened ACDTs	**Constant watches**	**Comments**
September	16	15	Main reason Suicidal Thoughts
October	10	8	Main reason threats of Self Harm
November	21	10	Main reason Threats of self-harm linked to imminent removal - Increase in Charter flights
December	26	12	Main reason Threats of self-harm linked to imminent removal - Increase in Charter flights

132. PPG notes the absence of Rule 35 (2) reports having been completed during this period despite the numbers on constant supervision due to 'suicidal thoughts' or 'self-harm'. This

[3] All of the 'no' responses have been chased to the Home Office on several occasions.

will be subject to further review by PPG and will be benchmarked against Rule 35 activity in IRC Heathrow in due course. PPG is actively developing a training package for GPs undertaking Rule 35 assessments and this will be ready for implementation by 1 July 2022. The increase in provision of Mental Health clinicians will also further support the management of patients on constant supervision and the Rule 35 process.

Compliance with clinical standards

133. With regard to Rule 33, clinical professionals are registered with the relevant professional body and registrations are checked on appointment (or in the case of contract commencement, on TUPE transfer) and a system is in place to identify those whose registration is expiring to ensure that full registration is maintained. All GPs are registered with the GMC and on a performers list to practise as GPs. Assurance of this is provided by our GP subcontractor, Dr PA.

134. Training is provided to all staff as outlined earlier in the statement to ensure up to date skills and clinical practice. Mandatory training related to medical confidentiality is completed on an annual basis.

135. Our administrative team make every effort to obtain medical records from the community where possible and the team have access to SystmOne records where someone has transferred from a prison or other IRC. Similarly, medical records are transferred at discharge where it is known where a patient is going (for example, back to a community setting or another IRC). If transfer of records is not possible, patients are given a copy of medical records to take with them. Healthcare will also attempt to facilitate any reasonable requests to see a second opinion doctor.

136. Our new reception processes, planned within our service development plan, aims to increase awareness of and attendance at Rule 34 appointments, recognising the low attendance rate at these.

137. With regard to Rule 35, we complete a data audit to the Home Office each month with the numbers of Rule 35s completed. As noted above, PPG will introduce formal training in the completion of Rule 35 reports to improve quality. There is currently no audit available to examine the quality of Rule 35. PPG are planning to develop a new quality audit which will

be peer reviewed between IRCs and a foreign national prison. This is yet to be finalised but once completed will form part of the audit schedule for IRCs.

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 willing for this statement to form part of the evidence before the Inquiry and published on the Inquiry's website.

Signed…. **Signature** ……

Dated……16.02.2022 ……