Root Cause Analysis Investigation Report

Brook House

Incident Investigation Title:	Brook House serious incident (STEIS 2017/22218)
Incident Date:	August 2017
Author and Job Title	Andy Cook - Chief Nurse Haider Al-Delfi - Associate Director of Governance
Investigation Report Date:	May 2019

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Incident Investigation

Incident description:	On Thursday, 24th August 2017 G4S received a letter from the BBC advising of a programme to be aired on 04/09/2017 examining concerns about the Immigration Removal estate and removal process across the UK. The programme primarily featured specific concerns about the management and conditions of Brook House Immigration Removal Centre. It is important to note that the issues raised related to the approach of all staff across the IRC and not simply those in the healthcare team. This review has focussed on the healthcare team given that is the remit of G4S Health Services, but inevitably reflects issues that were more systemic across the entire IRC service. A number of G4S named employees were featured in this programme in the context of 2 x incidents described by the BBC as the follows (*Anonymised*): ○ *"Staff member said that detainee X who had tried to strangle himself repeatedly and swallow a mobile phone battery was an arse basically".* ○ *"There were 2 restraints of the same detainee on E wing. The 1st was recorded. Staff were present for the 2nd physical restraint where an officer in an apparent attempt to render the detainee unconscious choked the detainee. There was no use of force report made after this restraint. Staff member made a deliberate incomplete record of this incident omitting use of force by officers".*
Incident date:	August 2017
Incident type:	Abuse and mistreatment of patients
Department:	Brook House Immigration Removal Centre

<table>
<tr><td>Immediate Action Taken</td><td>
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<tr><th colspan="3">Immediate Actions</th></tr>
<tr><th>Date</th><th>Action</th><th>Outcome</th></tr>
<tr><td>26/08/2017</td><td>Staff member asked for a response to comments made by the BBC</td><td>Staff member referred to NMC</td></tr>
<tr><td>26/08/2017</td><td>Medical Director conducted a case review of the patient concerned and reviewed clinical incidents reported for the period Jan-Aug 2017</td><td>A case investigation report with recommendations for learning</td></tr>
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<tr><td>Investigation scope, process and method</td><td>This review was independently undertaken by G4S Health Services Chief Nurse and Associate Director of Governance to establish why the incident happened, what lessons have been learnt and what has been put in place to prevent future reoccurrence.

The investigation team utilised an adapted root cause analysis approach that focused on learning and system-level change. This adapted methodology was deemed necessary due to the length of time that has passed since the date of the incident.

The review comprised of three key components:
● A review of existing resources surrounding this incident
● Interviews with Brook House management team
● A facilitated workshop with the wider Brook House team</td></tr>
<tr><td>Involvement and support of patient and / or relative - including Duty of Candour</td><td>Letters were sent to all patients with an expression of regret and information about the planned investigations. The Managing Director visited the site the following day and on further occasions.</td></tr>
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Detection of the incident	G4S Health Services was first made aware of this incident after a letter was received from BBC Panorama producer on 24th August 2017.
Contributory Factors	*Treating people with dignity and respect* • Staff cultural institutionalisation systemically across the IRC • Lack of attention to dignity and respect systemically across the IRC • Divisions between the healthcare team and Custody & Detention team at Brook House and a "Cliques" culture within the healthcare team *Supporting staff to deliver safe and compassionate care* • Poor incident management • Lack of clinical protocols and clinical guidance to support staff • Lack of clinical supervision and gaps in employee development reviews • Inadequate/insufficient staff training and development • Lack of robust leadership within healthcare *Speaking up and reporting concerns/complaints* • Lack of confidence and difficulties in raising concerns • Staff not confident in recognising what needs to be escalated systemically across the IRC • When complaints/concerns were raised the perception was that they weren't dealt with *General atmosphere and culture* • Bullying and blame culture in the centre • "Them" and "Us" culture between officers and healthcare.
Root Causes	• Staff cultural institutionalisation across the IRC more widely led to patients not being treated with dignity and respect. • Staff were not supported to deliver safe and compassionate care. • Failure of speaking up and reporting concerns/complaints systems. • A dysfunctional atmosphere and culture that enabled bullying and blame systemically across the IRC

Recommendations for the healthcare team	• Improve professionalism and professional boundaries • Build and improve healthcare team working dynamic, with a particular focus on cohesion and bonding. • Improve partnership working between healthcare and the Custody and Detention operational team. • Ensure staff are suitably trained in Equality and Diversity and how to deliver a culturally sensitive service. • Improve the incident management process, with a particular focus on supporting staff to recognise what warrants reporting. • Improve post-incidents debrief and feedback to staff following incidents • Improve SystmOne templates to aid staff in delivering care in line with agreed clinical protocols and guidance. • Improve clinical supervision provision and Employee development reviews • Improve the quality of training offered to staff • Enhance leadership and management support • Introduce ways to capture staff suggestions through formal and informal means • Improve the whistleblowing process • Introduce Freedom to Speak Up Guardian • Improve the complaints and investigation process at Brook House
Arrangements for sharing and learning	Discuss report at G4S Health Services Serious Incidents Committee and ensure robust organisational wide systems are in place to prevent reoccurrence at Brook House and other G4S Health Services establishments.

Action Plan progress update

No	Root Cause	Action	Status	Evidence
1	Staff cultural institutionalisation led to patients not being treated with dignity and respect. A dysfunctional atmosphere and culture that enabled bullying	Undertake reflective supervisory session to help staff consider their professional boundaries and how to deliver safe professional care in line with respective codes of conduct.	Ongoing	Staff reported a more professional working environment is now in place at the centre. This is an ongoing piece of work now led by the newly appointed clinical lead with organisational support by G4S Chief Nurse
2		Build and improve healthcare team working dynamic, with a particular focus on cohesion and bonding.	Ongoing	Staff confirmed that team working has improved within the healthcare team. Further work needed to improve working dynamic between Nursing-HCA. And permanent-bank/agency staff.
3		Improve partnership working between healthcare and Custody and Detention operational team.	Complete	New Director in place and feedback from staff confirmed improved partnership working at the centre
4		Enhance leadership and management support	Ongoing	Improved role and visibility of the Director at Brook House, with increased presence on the shop floor.

				New clinical lead in post Staff reported improved management support but further work is needed to bridge a perceived divide between the management team and front-line staff
5	Staff were not supported to deliver safe and compassionate care.	Ensure staff are suitably trained in Equality and Diversity and how to deliver a culturally sensitive service.	Complete	Annual Equality and Diversity training mandatory for all staff, compliance monitored via Learning & Management System Team diversity has improved Further on-site diversity and cultural training recommended
6		Improve the incident management process, with a particular focus on supporting staff to recognise what warrants reporting.	Ongoing	Staff utilise the centre IR system and InfoExchange to report health services incidents. G4S Health Services will start using Ulysses in July 2019. Staff confirmed there is now an improved recognition of what constitutes an incident.
7		Improve post-incidents debrief and feedback to staff following incidents	Complete	Staff reported improved post-incident debrief and feedback following incidents when reported through the CADS route. Further improvement can be made on thematic learning from CADS

				incident reports. Feedback to reporters will further improve through an automated process utilising Ulysses.
8		Improve SystmOne templates to aid staff in delivering care in line with agreed clinical protocols and guidance.	Complete	Improved SystmOne templates in place. SystmOne templates are subject to continuous improvement.
9		Improve clinical supervision provision and employee development reviews	Complete	All clinical staff received regular clinical supervision with exception to senior nurses. Clinical lead is now in post and will ensure senior nurses receive regular clinical supervision EDR not completed for all staff.
10		Improve the quality of training offered to staff	Complete	Staff confirmed there is improved access to training and quality of training offered Training is subject to continuous improvement under the learning and development workstream
11	Failure of speaking up and reporting concerns/complaints systems.	Improve the whistleblowing process	Complete	Global G4S "Speak Out" system implemented by Navex - a global company trusted by over 10000 organisations worldwide.
12		Introduce ways to capture staff suggestions through formal and informal means	Ongoing	Staff suggestion box available for staff to use but not used regularly. Further work required to

				further encourage staff participation in service development. Staff felt formal methods can be restrictive at times and would welcome a mixture of formal and informal methods to escalate and discuss issues and suggestions.
13		Introduce Freedom to Speak Up Guardian	Complete	G4S Health Services Freedom to Speak Up Guardian in post.
14		Improve the complaints and investigation process at Brook House	Complete	Clear complaints and investigations process in place.