BROOK HOUSE INQUIRY

FIRST WITNESS STATEMENT OF KAREN CHURCHER

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 23 September 2021.

Any references to G4S Health Services (UK) Limited in this statement have been abbreviated to "G4S".

I, Karen Debra Churcher, of DPA will say as follows:

Background

1. My full name is Karen Churcher and my date of birth is DPA

2. I first qualified in 1993 as a Learning Disability Nurse. I then completed a conversion course in 1998 and became a Registered Mental Health Nurse ("RMN"). I have got a diploma in counselling and I am qualified to teach students. I worked for Surrey Borders NHS Trust until 1998 and then I went to work for the Priory. I have always worked in forensic units and I managed the medium secure end of that hospital until 2014. I moved to work for Boots in November 2013 until April 2016 where I completed a pharmacy dispensing course. I then went to work for G4S at Brook House. Two of my friends worked in the mental health team and I missed nursing, so I went back. I worked at Brook House until 30 October 2018 when I left to work for Sussex Partnership NHS Trust doing dementia assessments. I still work in that role now.

3. I started working for G4S at Brook House as a RMN. I worked 40 hours a week. I worked 3 shifts one week and 4 shifts the next week. Each shift would last for 12 and a half hours. In around June 2018, I was then promoted to senior nurse and worked 4 days a week doing 10 hour shifts. When I initially began work at Brook House, we were also expected to work nights occasionally to cover for the Registered General Nurses ("RGNs").

4. I left G4S on 30 October 2018 Sensitive/Irrelevant

Sensitive/Irrelevant

Application Process

5. One of the main reasons for me wanting to work in healthcare at Brook House was that I had always worked in forensic settings and wanted to try something different. In normal mental health hospitals, nurses would be expected to restrain patients, but we did not have to do that at Brook House. I felt that Brook House would be a safer setting than a mental health hospital.

6. I felt that the recruitment process prepared me for the role I was about to undertake at Brook House. All of the interviews are held in the unit, so you were instantly able to get a good feel for the environment and familiarise yourself with the setting.

Culture

7. I worked within the Healthcare department during my time at Brook House. The Mental Health Team had a separate area in the healthcare department to the physical healthcare team, but I always found all healthcare staff to be helpful and supportive. Healthcare was seen as separate to the main staff of Brook House and a lot of the wing staff did not know that we were employed by G4S, as we were in a different office and so segregated. In order to access our office, you had to go through two or three locked doors.

8. The Healthcare managers were always around to provide help and assistance. If any members of staff needed to see them, we could simply walk into the office without making an appointment. In my experience, wing staff were often understaffed. In relation to the wing staff, there was often only 3 members of staff to every 100 detainees. Wing staff escorted healthcare staff to each room and were always very considerate. I never had a problem with any of them. I did not see any behaviour that raised concerns in relation to the behaviour of wing staff. Had I witnessed anything of the sort, I would have raised it with my line manager. From a mental health point of view, some of the wing staff did not have much training in that area. The detainees used to receive appointments from us and if they did not come to see us, we would go to the wings to find them.

9. Brook House was understaffed before, during and after April to August 2017. I felt that staff morale was low, as everyone was always so busy due to there not being enough staff members to meet the workloads.

10. I didn't see anything that concerned me in relation to wing or healthcare staff attitudes towards detainees. Situations could sometimes become quite volatile but I thought that they were handled well by staff members. Had I witnessed any concerning behaviour, I would have reported it to my line manager.

11. I did not have any concerns about how individuals were treated in any respect. Wing staff could have done with more training in relation to the physical and mental health of detainees to help them understand their conditions. There were incidents where detainees might be mentally unwell and make their rooms purposely dirty with urine and faeces. Wing staff did not understand that this was because detainees were scared and wanted to keep people as far away from them as possible. Detainees would make the environment around them very uninviting as a type of coping mechanism. When the drug and alcohol detox beds were introduced, I don't think some of the wing staff understood how important it was that detainees received their timely medication.

12. I was not aware of any occasions when a member of healthcare staff raised concerns about the treatment of detainees. Had I been aware, I would have encouraged them to raise it with a manager or I would have raised it with my line manager.

Oversight

13. I have listed below my understanding what various bodies did and how they were involved at Brook House based on my contact with them:

    i. ***The Independent Monitoring Board (IMB);*** The IMB were present around the wings and they took part in some of the review meetings. I was in regular contact with the IMB. They are completely independent and look out for the welfare of the detainees and make sure everything is being done properly and procedures are being followed. If they had any concerns regarding the welfare of detainees, they would raise it with members of staff.

    ii. ***The Gatwick Detainees Welfare Group (GDWG);*** I had no contact with GDWG. I used to refer detainees to them but I don't know much about them.

    iii. ***Medical Justice***; Medical Justice is a charity and assists detainees who have a medical claim to stay in the country. We would give detainees the contact details for Medical Justice.

    iv. ***Bail for Immigration Detainees (BID).*** I did not have much contact with BID. They were there to assist detainees with their bail applications.

    v. ***And other external organisations.*** Healthcare were in contact with MIND, the mental health charity and the drug and alcohol team.

General Training

14. I had a 2 week induction when joining G4S. I was not given any sets of keys until all induction training was completed. The initial induction training was done in Brook House by G4S. I had breakaway technique training, which covered what should be done if a detainee attacks you. I also had ACDT and ILS (immediate life support) training. There was online training which covered diversity, fire safety and all mandatory training relevant to my role.

15. The training was fine. I think it prepared me for the role but the induction training seemed to focus more on the practicalities. I think it would have been beneficial to include training on the Home Office and their policies.

16. All of the training sessions that we received as staff members was necessary to fulfil our roles.

17. In relation to training, I think it was adequate however more information could have been provided to help understand the role of the Home Office.

18. I can't remember if I was offered refresher training courses. I think I may have been offered ACDT online refresher training. I think Home Office training should have been offered on an annual basis.

19. I attended ACDT and breakaway training courses provided by G4S. I do not have the details or dates of that training.

20. I received control and restraint training during my induction in April 2016. I do not recall receiving any refresher training throughout the rest of my time at Brook House. We did not receive any Rule 35 or ACDT training until around a year after I joined Brook House. We had already been implementing ACDTs at this point but we had never received training about them. I think G4S thought that we didn't require ACDT training because we never opened them ourselves but we did. Anybody could open ACDTs for detainees. Everybody got the training eventually.

Staff Induction

21. I had an induction that lasted two weeks. On my first day, Michael Wells and Sandra Calver conducted the induction. I was then introduced to the senior mental health nurse, Ann Herbert. I spent the rest of my first day with her and was given copies of all of Brook House's policies and procedures to read and familiarise myself with. The senior mental health nurse showed me around the unit. Once the induction was complete, I was given my own set of keys. I was taken out on to the wings on the second day of my induction and I was also taken to Tinsley House. This is where I had my key induction.

22. I think the staff induction process prepared me well for my role at Brook House. I think more information could have been provided about the Home Office and their role, as that part was very new to me. I had worked in secure settings before but I was not familiar with Rule 35 reports etc.

23. Not having your own keys during the induction made it difficult. I had to rely on other people to take me around the centre. I could not even go to the toilet without being chaperoned by someone else, as the door needed to be unlocked. It was also quite difficult to get used to the new systems within two weeks.

24. I think more information could have been provided about the Home Office and the different levels in the Home Office system. Often people from the Home Office would request information about detainees and healthcare staff would be reluctant to give it, as we did not know who they were and we did not want to breach medical in confidence. If we had more awareness and understanding about their roles, we would have felt more comfortable passing information on.

Management of healthcare staff

25. In 2017, Sandra Calver was the Head of Healthcare and Michael Wells was the Practice Manager at Brook House. Anything clinical would be under the care of Sandra and everything else fell under Michael. They both worked Monday – Friday from 9am until 5pm and they were always on call, so if ever you had any issues outside of their working hours, you could still contact them. For most of my time at G4S, there was just one member of admin staff. On a daily basis, there was at least one RMN for at least part of a shift. There should have always been three RGNs and two healthcare assistants but as long as there were at least two RGNs, there could have been more healthcare assistants on shift. A GP was present at Brook House

every day and they also used to cover Tinsley House. RMNs also used to cover both sites during a shift but there would be separate physical health staff down at Tinsley House.

26. James (Jim) Newlands and Daliah Dowd reported to me as their line manager. They were both RMNs.

27. I had a good relationship with senior managers in healthcare at Brook House. They were always available out of hours by telephone and could always be found during office hours. I was always able to contact Sandra regarding any clinical queries, there was never a problem. I didn't need to contact Michael as much but they would both always be in their office if they were needed. Their offices led out into the waiting room where detainees would be. If situations ever got out of hand in the waiting room then both Sandra and Michael would come out of the office to assist the nurses. They were always there to help.

28. Both Sandra and Michael good managers and I never had a problem with either of them. I got good feedback. I also had external supervision from the Head of Forensic Services at the Trust that I work for now. We sourced beds from the Trust for mental health patients at Brook House and one of the occupational therapists used to come into Brook House to run group sessions. They also conducted my clinical supervision.

29. There used to be walk in clinics every day run by the RGNs. They would then decide whether the detainee needed to see the GP or what was the problem. They would do a referral to us and we would then follow that up. We would also take referrals direct from the wards. Self-referral was also fine, if someone knocked on the door and needed to speak to us. The mental health team worked very well together. We were very close and supported each other in our roles. There was also always support from the wider healthcare team however the RGNs did not always have the required knowledge to fully support the mental health team.

30. During 2017, clinical supervision was allocated by Sandra. I carried out clinical supervision for other RMNs and one of the care assistants when I was a senior nurse.

31. My clinical supervision was provided externally by Karen Friel of Sussex Partnership NHS Trust. I did not experience any problems with my line management or clinical supervision.

32. We did offer shadowing to the wing staff at one point. I asked for it to be put in the induction that people were to come and spend a day with us so the wing staff would understand what we do and what our role is. I think this happened not long before I left. I don't think anything could be improved in relation to line management and clinical supervision.

Disciplinary and grievance processes

33. I was not involved in any disciplinary or grievance issues.

Staffing

34. Brook House was always understaffed. Wing staff and healthcare were understaffed. We used agency staff to help fill the gaps however when we were understaffed at short notice due to staff sickness, it was not always possible to get agency cover.

35. The problems with low staffing levels did not impact on the standard of healthcare provided to detainees. Detainees got access to NHS resources quicker than the general public. If they desperately needed to see a doctor, they would be fast tracked. The Home Office needed them to be well to be deported. I think in relation to healthcare, detainees got a much better service than they would in the community. They would go to different specialists in different areas for example, if they were already under the care of a cardiologist in Birmingham, they would go to Birmingham to see that cardiologist. I don't think there were ever problems with detainees needing to see a mental health nurse. The longest wait was 7 days. I did not raise the staffing issues at any point, it was always something that we raised internally within Healthcare but I did not raise a formal complaint.

36. G4S did use agency staff. I am unsure of the proportion of permanent staff to agency staff. Any individual who worked at Brook House had to undergo Home Office checks and have security clearance. There was a core bank of agency staff that were used and they knew Brook House well.

37. Agency staff were experienced at working in secure settings. We would see the same staff members returning from the agencies.

38. I don't know what training or induction was provided to agency staff. The same members of agency staff were usually used at Brook House so they knew the centre and systems well.

39. I don't think the number of agency staff generally affected the provision of healthcare to individuals because it was usually the same members of staff returning therefore they knew the procedures and knew the centre well.

40. On some occasions, some clinics that were deemed less essential than others would be cancelled and postponed to another week due to staff shortages. In mental health, we used to run group sessions and needed staff to run these sessions. If there were first responses that required our attention then this would mean clinics would have to be shut as all nurses would be busy responding.

41. The staff shortages did impact negatively on staff morale, as everyone was overworked. Many members of staff were working extra shifts to fill the gap.

42. Detention staff were understaffed a lot of the time. There were around 3 staff members to every 120 detainees.

43. The detainees are locked in their room from 10pm until 8am. They are unlocked and at 9am the wings are unlocked, so the detainees can wander around the centre. Activity staff used to

run things such as arts and crafts groups and the gym. Sometimes there would not be enough activity staff on shift, so the gym could not open for example. This was a regular problem.

Relationship between Healthcare and Detention Staff

44. I never had a problem working with the detention staff and I thought that they were quite considerate. They faced quite a lot of abuse from detainees. They always tried to be considerate and they were always good to healthcare staff.

45. I think I attended two use of force incidents during my time at Brook House. RMNs generally did not attend use of force incidents unless there were no RGNs to attend. The way it worked was most use of force incidents were pre-planned, so you got called and asked if you could be there and you were asked if there were any relevant healthcare issues that they needed to be aware of and then when the actual incident took place, you were there to oversee and ensure that the detainee did not come to any harm.

46. Supported living plans are put in place by healthcare if there are any healthcare needs that the officers needed to know about and to check on. For example, I had a patient who was a schizophrenic and he did not want other detainees to know. He was just quiet, and had a supported living plan in place so officers would go and stick their head in and make sure he was ok. We would check in on him as well but it made officers aware.

47. I thought most detention staff overall had a good attitude towards detainees. I thought they had a lot of patience. I did not see anything of concern or I would have raised it with my line manager. I never experienced any problems with the relationship between healthcare and detention staff.

48. Staffing levels could be improved in order to ensure that all clinics and activities for detainees always go ahead as planned.

Relationship with Home Office

49. In my role as a senior, I had a lot of contact with the Home Office. They were located on the floor above us in the same building. We had to conduct Rule 40 reviews on a daily basis, so the senior managers would be in attendance. If we had a patient that we knew was unwell, we would ask the Home Office if there was a flight booked for them. Sometimes the Home Office would contact us to inform us that there was a detainee arriving who would need mental health care. The Home Office would receive external reports from Medical Justice and they would ask for our input on it and whether we agreed with it. I had a close working relationship with the Home Office throughout my career, more so in my senior role. I haven't got any individual issues with Home Office staff. The only thing I remember is when I was having trouble getting a bed for a patient to be admitted on a Saturday, as the hospital was insisting they do not admit over the weekend. I informed the Home Office and they got in contact with the hospital manager and a bed was found for the patient within the hour. They were always very helpful.

50. I have a vague recollection that I once raised an issue with the Home Office that was investigated. Medical Justice were sending their representatives to talk to the detainees and I

noticed that three reports had been received from Medical Justice, written by the same person. All three reports were exactly the same in content and only names had been changed. I raised it with the Home Office and it was discovered that the Doctor had not been there on one of the occasions and had not even examined the detainee. I'm not sure what the outcome of this investigation was, but I remember I was told about this as it had been escalated to more senior colleagues. Unfortunately I can't remember any further information or detail about this incident.

51. The Home Office had to do their job and this sometimes provoked responses from the detainees, which healthcare staff sometimes had to deal with. This did not prevent us from providing healthcare services to detainees.

52. I think it would be beneficial for healthcare and wing staff to have more of an understanding of the Home Office and their involvement. We didn't have a great understanding of how the processes worked, so this would be helpful.

Reception / Healthcare Screening / Induction

53. I have been asked to provide a description of the usual reception healthcare screening process for individuals on their arrival at Brook House. The mental health team did not really get involved in admissions. Occasionally, if a RGN was unwell or the team were understaffed, I would be asked to go and conduct an initial assessment on a detainee but other than that, I was not involved. I don't know whether the screening was done during the day or night. I think there were set hours.

54. Brook House had an admissions suite. All admissions would take place there. Healthcare assistants usually carried out healthcare screening on new arrivals. This would always be supervised or signed off by a RGN. We had 24-hour access to interpreters. They were very easy to get hold of over the phone. I don't know if the detainees were given written materials telling them about healthcare as part of the screening process. All detainees were taken around the centre upon arrival and shown where healthcare was situated.

55. Sometimes we would have to ask the detainee to give consent for their medical records to be faxed over as they didn't arrive with any records. A form of authority would have to be signed by the detainee and the GP would request their previous medical records.

56. If someone arrived with medication in their possession they would be assessed to ensure they were fit to have it in their possession and were aware of how much to take and were not at any risk of overdose.

57. If someone arrived on medication but didn't have it, staff would apply for the detainee's GP records to review and confirm that the detainee had been prescribed that medication. The detainee would also see the GP the following day and the GP would conduct an assessment. If we could not prove the detainee had been prescribed the medication or the GP didn't think the detainee required it, it would not be given.

58. If there was proof that the detainee was suffering from a health condition on admission, we had some stock medications that we could prescribe in an emergency. The GP would see all detainees the day after they arrived in the centre, so he would further assess. We needed hard proof that the detainee had been taking this medication already. The detainees' medical records would be checked to verify this.

59. Healthcare were usually informed beforehand if a detainee was coming to Brook House and was suffering with a mental health condition. We would receive an e-mail from the Home Office or another detention centre. They would usually have a two week supply of medication on arrival.

60. The detainees would be assessed on an individual basis. If someone needed monitoring more closely, they would be placed on E-Wing. E-Wing was a small wing and had close supervision units.

61. If someone had a substance misuse issue, we would assess the level of risk and manage them accordingly. The detainee might be placed on E-Wing for close observation or if the condition could be managed, then they would be sent to B-Wing with the other detainees but monitored at a higher level than normal. This was the same for someone who was at risk of self-harm or suicide. Everything was assessed on an individual basis.

62. The detainees either stayed on B-Wing or E-Wing for their first night in the centre. E-Wing was much smaller and sometimes detainees would spend their first 24 hours there or longer if required.

63. When individuals first arrived at Brook House, they were automatically booked in for a GP appointment the following day. The GP would assess them and review any medication that they were on. If detainees needed access prior to this, they could request to see one of the nurses. This was standard procedure.

Healthcare Facilities and Equipment

64. Primary care services was in a different location to mental health services. There were three doors that led into physical health. The middle door was where the patients went, if you looked straight ahead there was the pharmacy. To the left was a consultation room and a bit further up there was another consultation room. In the morning the nurses did their triage in the consultation rooms and in the afternoon the doctors conducted their surgeries and the nurses filled out their paperwork.

65. Mental health was based across the corridor in the visitor's area with one office area. There were normally two nurses on shift during the day and then one nurse went over to Tinsley House. We would sometimes book space in the visiting hall to do group sessions.

66. Brook House needed a dental suite. That would have been very helpful. We had access to external facilities and if a detainee needed urgent treatment, they would go out to hospital.

67. From a mental health view, equipment was not necessary to deal with the health conditions presented by detainees.

68. In relation to the physical environment in healthcare, there was an issue with detainees providing urine samples. As there were no toilets within healthcare, they would have to take the sample pot away and bring it back. We were reliant on the detainee's honesty, as we did not know that it was definitely their sample. The rooms were also very small when checking detainees in.

69. I don't think there were any problems with equipment, healthcare had everything they needed to treat detainees. In terms of improvements, more space in healthcare would have been beneficial.

Access to Healthcare

70. Primary care conducted triage sessions every morning from 9:30-11:30 in which detainees could attend and see the nurse without an appointment. There was a GP on site every day and RGNs assisted with booking appointments and liaising with external services. RGNs offered physical health checks on the wings for detainees who were not able to make their way to healthcare. Upon detainees' admission into Brook House, they would have a healthcare screening with the RGN and a GP appointment was booked for each detainee within 24 hours of their arrival. GPs covered both Brook House and Tinsley House and were also on call. There were paramedics and healthcare assistants on site and they assisted with the First Responses. RGNs also did food and fluid checks for detainees who were on hunger strike.

71. RMNs did not have any care assistants. We offered access to group sessions and arranged appointments with the psychiatrist and/or psychologist. The psychiatrist came to brook House once a week and further appointments could be arranged as and when required. We had a service agreement with the local mental health hospital that stated they had to offer us a bed for any detainees who needed it. We also had an external occupational therapist that came into Brook House and ran group sessions. Addaction were a drug and alcohol team that offered group and one to one sessions. If it was discovered that detainees needed follow on support, we offered weekly sessions until it was felt they didn't need any more. We would check some detainees first thing in the morning and make sure they got their medication on time. We got involved in the ACDT reviews, Rule 40 reviews and any other reviews that were happening on the wing. We liaised with Home Office and I was also a member of the safeguarding group committee.

72. When detainees first arrive at Brook House, they go through the health care screen check and they are automatically booked in to see the GP the following day. They will not be prompted to attend that appointment. The doctor will then do their review and if there are any issues then they will refer the detainee to the required service e.g. mental health services. If nothing was mentioned during the GP appointment but the detainee felt they needed support then they can attend the morning walk-in clinic and they would see the physical health nurses. If it was a mental health issue, the nurses would refer the detainees to us. The wing staff and managers

could also make a referral. Referrals could be made in writing or over the phone. If a detainee ever wanted to see a GP, they must first attend triage and be assessed by one of the nurses. Should a detainee want to see a psychiatrist, they would be assessed by an RMN and if the RMN felt it was necessary, the detainee would be referred.

73. When there were issues going on in the centre, for example, if the centre was on lockdown then people couldn't get up to go to the healthcare department and the officers in the wing would not be in contact with the detainees either. Unless they pressed the call button, detainees would not be seen. This was not something that would happen very often. Another issue was that the new detainees were not actually sure where healthcare was. All of the doors looked exactly the same and sometimes new detainees who had not committed crimes and lived peacefully in the community, did not want to leave their rooms out of fear.

74. Sometimes the detainees didn't come to the medication hatch at the right time to collect their medication, which would slow the process down and could create a bit of a delay. If staff were called to an emergency first response, the two nursing staff who were running the clinic would have to leave and attend the first response.

75. If the clinic was open all day, this would be a big improvement.

Detained Persons

76. The most significant health problems of the detained person population during 2017 was stress. Detainees felt that they could not escape from their problems and they did not know what the future held. Some people had never been in that environment before and they were petrified. Detainees' stress levels impacted their mental health and caused anxiety. Often detainees got angry and some resorted to drugs and spiralled into depression. This then impacted their physical health.

77. When managing these health conditions, it was difficult for healthcare staff as we did not have a solution for the detainees' stress and worry. If a planned removal had been arranged a number of times and not materialised, it was difficult to continue to tell detainees to be hopeful.

Interpreters

78. We used interpreters a lot at Brook House. We used both telephone interpreters and face to face. There were a few Chinese and Vietnamese detainees who did not trust the interpreters therefore we needed to ensure that face to face interpreters were requested on these occasions. Nearly all of the time, interpreters were available within 2-3 minutes of calling.

79. There would sometimes be some racial tensions between the detainees and interpreters, as some were bilingual. Detainees would allege that the interpreter did not like them because of the country they were from. Sometimes you would ask interpreters a simple question, but it was obvious the interpreters and detainees were chatting amongst themselves and it was difficult because you didn't know what they were saying. If it was a rare language, that could also be difficult to find a suitable interpreter.

80. From a mental health view, using interpreters allowed us time to gauge the reaction to a question and our work is to do with reaction etc. that gave us time to look at that without it feeling as though we were interrogating them

Supported Living Plan ("SLP")

81. My interpretation of an SLP was that it was there for detainees who needed extra support for example, someone who was deaf or had mental health issues. The wing staff were aware that this person had a problem. If the detainee gave permission, the SLP would state what the detainee's problem was and that the staff needed to keep a closer eye on them and engage with them a certain number of times per day. SLPs would be reviewed if detainees weren't coming for meals for example.

82. SLPs tended to be long term however they could also be opened on a short term basis for things such as mobility issues. Healthcare staff would open the SLPs and keep them under review as necessary.

Complaints

83. Detainees had to put complaints in writing and the wing staff would help them with that if necessary. I think there was a specific form that had to be filled out but I can't fully remember. There were boxes all over the wings for detainees to post any complaint forms and these were then collected by the Home Office and taken to the relevant areas.

84. All of the senior nurses had to process the complaints. I never had any complaints made against me. I think I carried out two investigations but I cannot remember what they were in relation to. When investigating, all notes would be reviewed and discussed with the detainee and any relevant members of staff and then a report would be prepared and given to a manager.

E Wing

85. The detainees who resided on E-Wing were deemed to be more at risk than the average detainees. There were 12 beds on E-Wing and two of the beds were specifically for drug and alcohol detox. There was a mixture of people. Some were there because of behavioural problems and some were there because they were vulnerable. There were two observation rooms at the far end of the wing and if someone needed to be observed constantly then they would be in those rooms. There was a locked door that went through to close supervision units. This is where the more violent and aggressive detainees were housed.

86. The detainees on E-Wing needed to be observed very frequently. They required a higher level of support and were more at risk being on B-Wing. Sometimes if somebody had been given a notice of deportation, they would be moved to E-Wing before they went if they had a history of resisting deportation.

87. We were very involved with the detainees on E-Wing. We would go to E-Wing every day and administer the medication for those that were not allowed off the wing. We would review the

constant observation detainees every morning and we would review the detainees in the close supervision units once a day.

88. If a detainee was a threat to themselves and others then they would be placed in CSU. Healthcare would administer the detainees' medication every morning and we would be present at the daily reviews to ensure that there were no healthcare issues.

Medication

89. RMNs never had anything to do with the management of medication for an individual who had been prescribed medication that could remain in their possession. I think the pharmacist was supposed to check and the GP would have the final decision on whether a detainee could keep it in their possession.

90. When detainees were obtaining medication, they would come up to pharmacy to collect it at the allocated times. Medication would be given 3 times a day, once in the morning, once in the afternoon and once in the evening. A little slip of paper would be sent to the wings, the detainees would be told that their medication was in and they would come and retrieve it.

91. Sometimes the detainees' medication would not arrive. When somebody was supposed to be removed, their medication would go with their luggage to be prepared for their flights and sometimes their flights would be cancelled or they wouldn't be able to board and then their medication would be stuck with the luggage. If the wings were in lockdown, the detainees could not come up to pharmacy for their medication either. If the detainees couldn't leave the wing on E-Wing, I know it was taken down to them.

92. I can't think of anything to suggest as an improvement.

Drug / alcohol misuse

93. If the detainee was already in the system prior to arriving at Brook House, the fact they had a substance misuse issue would be in their paperwork that came with them. Every detainee was screened for drug and alcohol on arrival and they would undergo testing. If the tests came up as positive, they would be referred to the mental health team.

94. Detoxing programmes were available to detainees. We had a "Forward" group that engaged with detainees. The treatment offered was always specific to the individual and we would recommend what we thought would be most beneficial to that person.

95. Forward Trust and the mental health team were available to support substance misuse issues. Forward Trust were based in Brook House and were there every day. They would receive referrals and then go to find the detainee to engage with them and provide further support. We worked alongside each other and conversed about the detainees and their progress.

96. I think the services and treatment available were both adequate. More effort could have been placed into keeping drugs out of Brook House but it was very difficult. Spice would come in as a result of being sprayed onto paper. It was very hard to detect.

97. There was a lot of Spice in the centre during the relevant period. It was very hard to control. There would be large amounts of emergency call outs every day.

98. If a detainee was under the influence of drugs or alcohol and needed immediate help, healthcare would be called as an emergency response. As a RMN, I did not really attend. Once detainees were stable, they were often referred to the mental health team in order for us to further assess. If it was a constant occurrence then the individual would be taken to E-Wing and their access to the centre would be limited.

99. There were weeks when emergency responses would be called every 15 minutes. I was forced to attend, as we were so busy. The rest of the detainees saw it as entertainment and they would all gather around. It was not an ideal situation. The emergency responses were always very quick. We would always see to the detainee immediately.

100. I did not have any concerns about how detainees with managed either by healthcare or detention staff. I never had cause to raise a complaint.

Mental Health

101. Sometimes when we were walking around the centre, if we noticed somebody who was not quite right. We would find out what wing they were on and ask the wing staff. Others would be referred to us and generally we would pick the referrals up twice a day and send out appointments. Generally there was a 2-3 day wait for an appointment and I think when staffing was tight, it probably went up to a week. We would then do an assessment. Some detainees thought it was a way out of detention, which it wasn't, so sometimes they weren't very happy with us and we were threatened on occasion. I remember we had a table thrown at us once. We continued to see those who needed help weekly or some were referred to groups. Some were prescribed medication, we would email the GP and the GP would write it up. Some would need to go on to see the psychiatrist. If we knew the detainees were going to be released, we would try to contact services outside and we would give them details of the nearest GP surgery. We then had to complete all of the paperwork for the Home Office. There was quite a lot of paperwork involved in that process. It was easier for the officers if we were there. We would get called to the wings if somebody had made a suicide attempt or something similar, sometimes we would be called in if the managers knew we were involved. Sometimes if something had kicked off on one of the wings, the manager would bring the patient into our room as it was a calming space. We would sit and talk and deescalate the situation.

102. Sometimes the physical healthcare staff's knowledge of mental health issues could have been better. On the whole, I think they were good but they had limited knowledge, as it is not their area of expertise. Some detainees were not necessarily mentally ill but they would try and present as being mentally ill and others would try and hide the fact they were mentally ill, which was sometimes difficult to manage.

103. I did not have any concerns about the appropriateness of detention staff management of individuals suffering from mental health conditions however, I think they would benefit from

more training. I did not have any concerns to raise. If I had, I would have raised this with my manager.

Rule 35 reports

104. I was not involved in writing Rule 35 reports. The purpose of a Rule 35 report was to see if somebody was fit for detention. I think we eventually got some training on Rule 35 reports but they changed the policy slightly.

105. I think the GP would make an appointment to see the detainee and conduct a physical examination and ask questions. If the examination was to do with a detainee's mental health, they would go through the notes on the system and see what was written and review the medication. The GP's report then got sent to Home Office and they made the final decision.

106. When determining suitability for ongoing detention, a detainee's mental health must be in a manageable state. I am not sure of the criteria for physical health. A Rule 35 report assessment is carried out via a face to face appointment with the GP.

107. I don't know who was responsible for ensuring compliance with clinical standards and the effective implementation of the Rules 33-35 of the Detention Centre Rules safeguards.

108. I think because all of the detainees wanted Rule 35 assessments, there was quite a backlog and they sometimes had to wait a while to be seen.

109. I had no concerns regarding the process of assessment and writing of Rule 35 reports. In terms of improvements, I think reduced waiting times for Rule 35 assessments would be beneficial.

ACDT and self-harm risk management

110. I have previously attended ACDT reviews and been involved in opening ACDTs on occasion.

111. Detainees would sometimes come to Brook House with paperwork advising that they had been at risk of self-harm or suicide elsewhere. If a detainee stated that they were having any thoughts of self-harm then we would open an ACDT. Sometimes ACDTs would be closed within hours, as once detainees had settled in to the centre, they would be a lot calmer. Occasionally, we would receive referrals from wing staff and conduct assessments following that.

112. Anyone could open an ACDT. Whoever opened one had to inform the manager who was in charge of the wing for that day. I opened a number of ACDTs. I would ensure that once they had been opened, the document was taken down to the wing with the detainee and I would explain to the officers what support the detainee required.

113. There would be a number of reviews once an individual was placed on an ACDT. The frequency of reviews depended on the level of risk. Reviews were sometimes done without a member of healthcare staff being present. I raised concerns with Sandra about this and it then became mandatory for healthcare staff to participate in all reviews.

114. I did not have any concerns about how detainees were managed. Everybody took the welfare of the detainees very seriously.

115. I did not have any concerns about how the detention staff managed detainees at risk of self-harm or suicide. I had a lot of respect for the wing staff. They were sometimes verbally abused and still managed to be very sensitive to the needs of the detainee.

ACDT

116. An ACDT is to identify anyone who is needing extra support and who might be at risk. It could be that they are an angry person or they are self-harming or they just need more help in general.

117. Sometimes detainees would already have an ACDT from another centre. One might have been opened if the detainee had been in a fight or if they were self-harming or taking drugs. Sometimes a detainee was placed on one if they had received upsetting news such as a family member passing away.

118. I don't think there was a threshold for opening an ACDT. ACDTs had to be reviewed within the first 24 hours of being opened and sometimes they would be closed if someone thought they were not needed.

119. ACDT documents were in the form of a booklet. Once an ACDT was opened, the manager in charge for the day would be informed and the wing would be called to inform the officers. An officer would then come to healthcare and healthcare staff would explain why the ACDT had been opened.

120. The ACDT booklet would remain on the wing and if the detainee was going anywhere for example, to healthcare, an officer would deliver the booklet and a member of healthcare staff would write an entry and conduct a 15 minute observation of the detainee.

121. The reviews would happen at stated intervals. Detainees should have always been present at reviews but they would sometimes refuse to attend. We would go to their room and ensure that they participated but it could be difficult.

122. If it was felt that the detainee no longer required support or the risk was no longer there, the ACDT would be closed. The detainee would have to agree with this decision.

123. ACDTs were reviewed within the first 24 hours of opening. It was unusual that they were challenged. Many detainees felt safer being on ACDTs.

124. Healthcare were involved in the ACDT reviews. We had to review the ACDT booklets every day, we would chat to the detainees and make relevant entries in their ACDT booklets.

125. Sometimes detainees did not want to be helped. If they were on some sort of protest, they would often not engage with us. Trying to get everyone together at the same time to undertake reviews was often challenging. Set times to undertake reviews would have been helpful.

126. I did attend the weekly healthcare multi-disciplinary meetings. They were to discuss individuals who had been identified as needing more support. If I saw detainees who I thought were at risk then I would bring this up in the meetings and we would brainstorm ideas regarding how to help.

127. Healthcare staff did attend the Safer Community Meetings and Adults at Risk (AAR) Meetings held in Brook House attended by detention staff. We would discuss risk levels in relation to detainees. If someone was high risk, we would discuss how to decrease this level of risk and what we could do to minimise it. We would be gathering all of the information to correctly assess the risk and nullify it.

128. The mental health team would go and speak to detainees as soon as we were notified that they had been involved in a distressing event. We would ask if they wanted to speak with us and follow up with further appointments if necessary.

Food and Fluid Refusal

129. Healthcare would see the detainee every day if they had been identified as refusing food and fluid to check on them and complete paperwork. We would try to educate the trainee on the consequences of what they were doing. Healthcare would make a decision on whether to refer the detainee to hospital. We would keep the detainees under constant observation. We had to complete food and fluids forms. There were two forms that would be sent to the Home Office and one would also be given to the manager of the wing.

130. Brook House was the first time I had ever experienced a patient refusing food and fluids. It was not pleasant. The detainees were obviously in physical pain and were very weak. They did not understand the consequences of what they are doing. It was very distressing.

131. I think the management of detainees refusing food and fluid was handled well. Sometimes when the detainees were on the usual residential wings, they did not get as much support as they required. There were only four officers to every 120 detainees, so it was sometimes difficult to monitor.

Use of Force

132. Officers always carried out the use of force. Healthcare would advise the officers of any health conditions the detainee had, if the use of force was pre-planned. Healthcare staff would also be present at the use of force and our role was to make sure that the detainee was not at risk at any point. With control and restraint, it is importantly to ensure that a person's airways are always clear and restraints aren't breaking any bones.

133. If a detainee posed a risk to themselves or others and could not be contained any other way then force could be used. A use of force form must be completed for every use of force incident. There was a diagram of the body and any injuries had to be noted. These forms were sent to the Home Office and the unit manager.

134. Healthcare would always follow up after use of force incidents. We would see the detainee and assess any injuries.

135. I have been involved in a number of use of force incidents. One involved a detainee who was due to be deported and was moved to E-Wing. The use of force was to move him to E-Wing and he became very angry. I completed a use of force form following the incident and made relevant entries in the detainee's ACDT booklet.

136. I have witnessed a number of use of force incidents. I would always complete a use of force form. I did not have any concerns. I understood the need for use of force in a detention centre. It was only exercised when it was necessary.

The Panorama Programme

137. I knew who Callum Tulley was but I had never had a conversation with him.

138. I do not appear in the Panorama programme.

139. Staff morale was awful following the Panorama programme. I was angry. A lot of the footage is not taken into context and some of the incidents I saw, I was appalled at. If I had known this was going on, I would have done something about it. I felt responsible in some ways for not knowing that it was happening. It caused a divide between healthcare staff and wing staff. People had trust issues following the cameras being in the centre and staff were suspicious of each other.

140. The programme had a negative impact on detainees and they became angry. Detainees felt that all of the wing staff were violent and did not care about their welfare.

141. I am unsure of the process regarding underage detainees. That is not something the mental health team would be involved in.

142. I think safeguarding training was changed following the Panorama programme and I think more mental health training was added. These changes were helpful. The safeguarding training was a lot more proactive.

Specific Individuals

143. I have been asked whether I knew specific members of staff and I have listed them below:

a. Nathan Ring - Nathan was a manager. I had some contact with him during Rule 40 reviews and ACDT reviews. I never had any concerns about him or his professional conduct.

b. Steve Webb - Steve was a manager with detention staff. I had no concerns about him.

c. Chris Donnelly - Chris was another manager and I had no issues regarding him.

d. Derek Murphy - Derek was a detainee manager and I had a number of dealings with him. I thought he did quite a good job. He was excellent with detainees and there was one detainee in particular who would only respond to him.

e. John Connolly - John worked mainly at Tinsley House and he used to do the control and restraints. He also did breakaway training. I did not work much with him.

f. Dave Webb - Dave worked on E-wing as one of the detention staff. I did not have any concerns about him.

g. Clayton Fraser - Clayton worked at Tinsley House. During the Spring 2017 period, Tinsley House staff came to Brook House. He was a caring member of staff, I had no concerns about him.

h. Charles Frances - Charles was an E-Wing officer. I used to talk to him most days and I had no concerns. He went out of his way to get medical appointements for detainees.

i. Slim Bassoud - Slim worked in visits. I had some contact with him. At one point detainees had to come through visits to get to mental health, so Slim would inform us that our detainee was there for an appointment. I had no concerns about Slim.

j. Yan Paschali - Yan was on E-Wing. He came from a prison and he was very used to working in that type of environment. I did not have any concerns about his behaviour.

k. I don't know Kalvin Sanders, Aaron Stokes, Mark Earl, Sean Sayers, Ryan Bromley, Daniel Small, Daniel Lake, Babatunde Fagbo, Shayne Munro / Munroe.

l. Nurse Jo Buss - Jo and I did not get on, on a personal level, it was a clash of personalities. On a professional level, we worked together fine. I had no concerns about her professionally and no concerns about her views or behaviours.

Suggestions for Improvements

144. More officers on the wing were definitely needed. The wings were very understaffed. I don't have any other suggestions for improvements.

145. Every member of staff employed during the time I worked at Brook House would know about how the centre worked.

The topics identified above are not intended to be an exhaustive list and if there are other matters relevant to the Inquiry on which you wish to provide evidence then you should do so.

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 it's 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.

Signed: Karen Churcher Dated: 1st November 2021

Name: Karen Churcher