BROOK HOUSE INQUIRY

FIRST WITNESS STATEMENT OF MICHAEL WELLS

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 27 September 2021.

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

I, Michael Wells, of DPA will say as follows:

Background

1. ***Your name and date of birth;***

   My full name is Michael John Wells and my date of birth is DPA

2. ***A summary of your career (which explains any professional qualifications which you have, your professional experience and the roles which you have held in your professional capacity including your current role / job description);***

   I started my career as a medical record clerk at East Surrey Hospital. In February 2013, I progressed to G4S where I was employed as an administrative assistant based at Brook and Tinsley House. In May 2014, I was promoted to Practice Manager of Brook House IRC until March 2019. In March 2019, I was promoted to Senior Practice Manager where I worked at Brook House and Tinsley House and supported the regional team of Practice Managers across the prison estate for G4S Health. In December 2019 I left G4S to come to my current role which is Practice Manager at Groombridge and Hartfield Medical Group. Whilst I was at G4S, I managed all non-clinical aspects of the Health service. I was involved with rota management, HR, payroll, management of non-clinical staff. The role was very much operational.

3. ***An explanation of when you worked for G4S Health Services and in what capacity. Include all the roles which you held whilst employed by G4S Health Services and details of your working pattern. If you were not employed directly by G4S Health Services, in what capacity did you work at Brook House?***

   In my role as Practice Manager, I worked Monday to Friday. I was usually in work by 7am and left at 4pm or 5pm. Depending on workload I would stay later if required.

4. ***If you are no longer employed by G4S Health Services, an explanation as to why you left and when.***

   I left G4S in December 2019, as I didn't see my career progressing within G4S. I felt that it was the right time to move on, as I had been there for 5 nearly 6 years and wanted more of a

work/life balance. The G4S Health business also had lots of changes within regional and national senior management which was slightly unsettling.

Application Process

5. ***An explanation of what attracted you to working in healthcare at Brook House.***

I was working in a temporary role at East Surrey Hospital and was looking for a permanent role when I applied to work at Brook House. I read about Brook House and thought it would be a really interesting role, where I could learn new skills and would be dealing with people in challenging situations. I had never worked within a secure setting before.

6. ***Your opinion of whether the recruitment process prepared you for the role. Please explain your answer.***

I thought the recruitment process prepared me well for the role. I applied for the job via the G4S online portal. The G4S website was very informative and the interview process was thorough with a lot of questions. I had my interview on site in the office I was going to be working in and it gave me a really good understanding of the setting moving through the centre. The clearance process was very lengthy, it held everything up but it needed to be in depth, as it was important that we had the right people working at Brook House and therefore I understood why. There was good communication from recruitment managers and they kept all new applicants informed of progress. I thought the communication from the Home Office clearance team was poor.

Culture

7. ***A description of the culture of Brook House when you worked there. In particular, was there an identifiable culture across Brook House as a whole; whether there was a specific culture within the healthcare department or a department, area or wing in which you did not work; if there was, whether it changed over time; in either event, what that culture was.***

From memory, I felt the culture was fairly good across Brook House. There were lots of different types of staff and also a big turnover of staff within the security staff. Staff were generally quite positive. There were the usual kind of days when staff were not as positive but that is to be expected given the challenging environment and it wasn't a regular occurrence. Healthcare staff worked long days, around 12.5 hours per day. I think all members of staff had an understanding of the difficult situation people were in at Brook House. We knew we were there to provide a healthcare service to the patients along with physical and emotional support. I felt that there was a good balance of approachability and communication. I never witnessed any concerning behaviour within my staffing team and I would have addressed it if I did.

Post-Panorama there was a huge turnover of staff, mostly operational staff. There was a huge change in wing staff and this caused ability and experience levels to drop. This subsequently caused a decrease in positivity levels throughout the centre. In relation to Healthcare staff, we lost the one nurse who was dismissed and subsequently struck off, we didn't see a drop in

employed staff, we saw a drop in recruitment activity but we did not have a huge pool of staff to choose form. We didn't see a drastic change in our staffing – the main change was a drop in staff morale.

8. ***Your views on staff morale at Brook House immediately before, during and subsequent to the Relevant Period, both with regard to healthcare staff and other staff employed at Brook House.***

Generally, I thought that staff morale was high across Brook House. There was always good inter-department working and I don't recall any negative incidents. I think when the Panorama documentary was aired, that's when morale lowered drastically. Staff were upset, angry and there was a breakdown in trust, especially for staff who weren't involved in the Panorama documentary. People generally felt quite uncomfortable, some considered their ongoing employment. This affected people across the board and the whole sector. People distanced themselves from certain departments. Organisations such as the IMB were in a really difficult position. It did not stay low forever, it was just whilst people were getting to grips with what had happened.

9. ***A description of attitudes towards individuals who were detained at Brook House immediately before, during and immediately after the Relevant Period.***

My attitude towards residents didn't change following the Panorama documentary. I had daily contact with the residents. My office was in the middle of the centre, I had an open door policy for staff and residents were always welcome to come and have conversations. I don't think the attitudes of my team changed following the documentary, as we were always positive and supportive but we still had to be fair. Dealing with complaints, concerns and having contact with the residents was not a problem for me. Across the centre, that was my experience of other people's attitudes towards the residents as well.

10. ***Whether you have any particular concerns about how the values of G4S and / or G4S Health Services or any culture impacted upon the following:***

a. The general treatment of individuals who were detained at Brook House;

b. The management of individuals with physical health conditions;

c. The management of individuals with mental health conditions;

d. The management of individuals who could be considered vulnerable;

e. The management of individuals with substance misuse issues;

f. The protection of specific individuals from the type of abuse seen on the Panorama programme.

I don't remember having any major concerns regarding the treatment of residents across Brook House. People with physical health conditions would be managed across the centre,

I don't think managing individuals in line with G4S values was a problem. I think there was a lack of understanding. The wing staff did not have a good understanding of mental health when I started, this was clearly a training need. People could sometimes not differentiate between mental health and behavioural issues and that was an area that came under scrutiny.

The management of individuals with substance misuse issues developed with NHS England and the service did improve as it went on. I think in terms of G4S, there were always challenges around people with mental health. Operational staff were not given the tools to proactively manage the situation and this is definitely something that could be done better.

11. ***Whether you are aware of any occasions where a member of healthcare staff raised concerns about the treatment of individuals (either individuals or collectively), whether informally or as a "whistleblower" and the response to it and the reaction from detention staff management and healthcare staff management.***

I don't recall any occasions where a member of healthcare staff raised concerns about the treatment of residents. There was one incident post-panorama relating to a control and restraint procedure that was raised informally and I then raised it formally with the deputy director. There was a concern from a nurse regarding the position of an officer during a control and restraint. This then initiated conversations about the role of the nurse and when they should interject. I think we had good professional working relationships. There are always times when challenging conversations need to be had. This was the case before the Panorama documentary aired and I had no concerns about talking to healthcare staff. Having a conversation with anyone within the centre was not a challenge.

Oversight

12. ***Set out your understanding of the role of the following bodies, their involvement at Brook House and the nature of any interaction or communications you had with them.***

i. The Independent Monitoring Board (IMB);

The IMB were a resident advocacy team. They were completely independent and on site daily. They would attend contract meetings, partnership board meetings etc. They were an in house team of support for residents. We had a good working relationship with the IMB. Myself and the Healthcare lead would meet with IMB once a week and talk about Healthcare in general and complex cases. Any concerns would be raised at these informal meetings. Points from these meetings would often be added to the IMB weekly report. We supported the IMB annual report sharing information where possible.

ii. The Gatwick Detainees Welfare Group (GDWG);

GDWG were an external body. We had quite a challenging relationship with them as they were always requesting a lot of information and wanted to have an input into patient's care

when they're not qualified to do so. We were always sending information to them and having to constantly advise that we were dealing with different situations and that we couldn't give certain information out as this was medical in confidence information. We had a meeting to discuss this which the deputy director as well as the IMB, and it did improve. GDWG were very supportive to detainees and always gave them lots of advice and guidance. Operationally, they weren't particularly helpful and could take up a lot of valuable time. I think this was caused by a lack of understanding of the different roles within Brook House and what they are entitled to help with.

iii. ***Medical Justice;***

Medical Justice provide supportive legal aid. They are a registered charity and we would have regular dealings with them during information requests and site visits by practitioners to carry out assessments on residents. One of the medical practitioners from Medical Justice was very rude and abusive to staff. He was very abrupt in his manner and was a very challenging individual with us but always appeared to be supportive to the residents, however these consultations were in private.

iv. ***Bail for Immigration Detainees (BID).***

BID assisted residents with their bail application. We had some contact with them but not a lot. I am aware that they had drop in legal surgeries in the centre.

v. ***And other external organisations.*** We had regular contact with the NHS. They had heavy involvement with the centre. They sub-contracted to G4S health to deliver the services within the IRC.

General Training

13. ***A description of the general training you received before starting work at Brook House and/or upon starting at work at Brook House. Confirmation of when you attended this training, where it was held and who provided it.***

All staff had mandatory training before starting work at Brook House. All mandatory healthcare training was a range of courses from administrative perspectives for example health and safety. Staff undertook safeguarding training level 1, 2 and 3. Safeguarding training level 3 was face to face and levels 1 and 2 were online. Personal protection training and ACDT training was delivered by the centre. All mandatory training was done online apart from basic life support and safeguarding level 3, Personal protection, ACDT and security training surrounding keys etc. were all conducted face to face. G4S provided the training for personal protection, ACDT and security. Mandatory training including training for healthcare was done by an external training company called A&A Training Ltd.

14. ***Reflecting on this training, your opinion about whether it prepared you for your role at Brook House. Please explain your answer. If it did not adequately prepare you, please say what else you believe the training should have covered.***

I think the training sessions prepared staff for their role at Brook House. I didn't have any concerns with it at the time. A more detailed overview of control and restraint may have been beneficial but this was not part of my remit and therefore not required I assume. I would attend some control and restraints as a support function to the clinician, I was not heavily involved. Overall, I felt appropriately trained.

15. ***Reflecting on your time in healthcare at Brook House, what training do you consider was necessary in order to fulfil your role?***

Personal protection training was absolutely essential to fulfil my role at Brook House. Security training was also essential, along with ACDT training. I don't think anything was missed. It may have been beneficial to have de-escalation training, however this did form part of the personal protection training, as this was something I was not familiar with at the beginning of the role.

16. ***What, if anything could be improved?***

Online training was of poor quality and could be improved. The training provider changed in my final year at Brook House and they were much better. There needs to be more access to training and more choice and availability to staff. For new staff members who have never worked in a secure setting before, training sessions need to be done more than once. There needed to be refresher training on personal protection every year. Staff with no experience of secure settings or dealing with challenging situations needed additional training.

17. ***Whether you were offered, and attended, refresher training courses. If you did, please provide details of the courses. Was there any other training that you think should have been provided on an annual basis?***

I was offered refresher training courses for personal protection (once) however some training was annual such as the mandatory training. ACDT refreshers were available to operational staff but I think these should have been readily available across the centre. We had situations where people would open up to us about thoughts of self-harm and further ACDT training would have been useful to deal with this.

18. ***Whether you attended any of the training courses provided by G4S to its staff. If so, provide details.***

I attended personal protection, ACDT and security training. I felt the training was informative, and of a good standard. The personal protection training in particular was very engaging. Trainers were very good and tried their best to make the sessions light hearted in challenging circumstances. They tailored the training to explain how these skills were transferrable and could also be used in everyday life.

19. ***A description of the training you received on the following, including the dates on which you attended such training and any refresher courses on the following matters:***

b. ***Control and restraint (C&R) / use of force on individuals (including both planned and unplanned use of force). Please refer to the Violence Reduction Strategy (CJS000721);***

I don't have access to the dates I attended any training sessions as I no longer work for G4S. The Violence Reduction Strategy is a detention document not a healthcare document. I think I have seen this document in a meeting before but it was not a document I am familiar with. I attended two Personal protection training sessions, an initial session during my induction when I first started and one refresher in 2017/2018. The training covered an understanding of C&R, the reasons for C&R and the role of officers in C&R – it also trained you to be able to defend yourself There was very limited information on role of the nurse, which was very much about they have control of managing detainee in terms of health and had to say stop if force used was excessive. For me the session was not about using force, which is not something healthcare would ever do, it was more personal protection training rather than C&R. Overall I felt the first session provided good information and gave life skills for personal protection, it taught me how to gauge if a situation is safe, how to defend myself and how to raise an alarm.

c. ***Rule 35 assessments and reports; The management of individuals at risk of self-harm or suicide and the ACDT process including the threshold for opening an ACDT document, the management of individuals on an ACDT document and how to complete the documentation. Please refer to the following documents / policies:***

   (i) Suicide Prevention and Self-harm Management (CJS006380);

   (ii) Safeguarding Policy (CJS006379);

   (iii) Guidance for staff managing detainees on Constant Observations (CJS006378);

   (iv) Management of Adults at Risk in Immigration Detention (CJS000731);

   (v) Introduction to Safer Custody, Gatwick IRC's Caring for Detainees at Risk (CJS000052);

   (vi) Enhanced Mental Health Training, Gatwick IRCs Caring for Detainees at Risk (CJS000020);

   (vii) The management of individuals with substance misuse issues. Please refer to the Drug and Alcohol Strategy (CJS006083);

   (viii) Any other specific healthcare training.

The Suicide Prevention and Self Harm Management, Constant Observations, Enhanced Mental Health training and Safeguarding documents are all custodial documents, which I would not have been familiar with. We had our own safeguarding policy that covered health rather than the Centre and we would refer matters to Sandra Calver as our Safeguarding lead. I have seen the Introduction

to Safer Custody document as part of my ADCT training and am familiar with the Drugs strategy, which was a joint policy that was introduced when the substance misuse programme was put in place.

I never had to carry out a Rule 35 assessment or report as that was a clinical role for a General Practitioner. I don't recall attending training on Rule 35. I think I attended a forum about Rule 35 at Heathrow IRC when all of the other centres attended. We looked at policies and exchanged views and ideas about Rule 35.

I had ACDT awareness training, which included training about self-harm, but I was not taught how to open an ACDT. I think I attended one ACDT review maybe two in the whole of my time at Brook House. I don't remember attending any refresher training for ACDT, it was hard to get refresher training for personal protection or ACDT as there were not many sessions available. We asked regularly about ACDT and personal protection training.

I also had mandatory safeguarding training, level 1 and level 2 adults and children was done on line, and level 3 was done face to face. I believe Sandra Calver also did level 4 training and she was the safeguarding lead for healthcare.

I had all of the mandatory training as well as basic life support, manual handling, and I completed IOSH training for our sites.

Staff Induction

20. Please refer to Gatwick IRCs and Cedars Welcome Pack (CJS006391). Provide a description of the induction you received upon starting work at Brook House, including its duration, location, and who provided it.

My induction lasted about a month. I was in a non-clinical role so my induction was done by the practice manager at the time, Jacintha Dix. She inducted me to Brook House, Tinsley House and Cedars which was still open at the time. My induction covered all elements of the site, ACDT awareness, health and safety which was provided by the health and safety lead at the time, Mick Glennard. I was work shadowing for the first week, watching, understanding, learning. I didn't have keys to start off with as you have to complete your key talk and radio talk and this has to be signed off by security before you get your keys. I also had a tour around the site learning my way around. Effectively I was work shadowing learning the system and the day to day job for a month combined with training sessions provided by detention staff and healthcare staff.

21. Did your staff induction process prepare you for your role at Brook House?

Yes I felt my induction prepared me for the role.

22. What, if any, problems were there with the staff induction process?

I didn't feel there were any problems for me. I felt my induction for healthcare was good. I was given a good overview of the service, my role and responsibilities and was given time to understand this.

23. What, if anything, could be improved?

Staff should be given their personal protection and formal ACDT training at the very start of their induction along with the keys and radio training. It could take a long time to get keys and radios for staff which held up their induction and meant that staff couldn't even go to the toilet without asking for a colleague to take them until they had their own keys.

Management of healthcare staff

24. A description of how healthcare was structured in terms of line management and administration during the Relevant Period.

Sandra Calver was Head of Healthcare. Jacintha Dix and I worked as Practice Managers. Jacintha was based at Tinsley House and I was predominantly based at Brook House. Chrissie Williams was clinical lead and there were a series of senior nurses, staff nurses and paramedics. Healthcare assistants worked alongside healthcare staff and were managed by clinicians. Jacintha and I had an administrative assistant working with us.

25. ***Which staff, if any, reported to you as line manager? Please provide both names and roles.***

Pamela Neal who worked as an administrative assistant reported to me as line manager. Other administrative assistants also reported to me over my time at Brook House but I cannot remember the exact dates she worked at Brook House.

26. Explain your relationship with senior managers in healthcare at Brook House. Include details of the level of contact that you had with them, availability during shift for urgent/non-urgent queries, approachability, and visibility.

I reported to Sandra Calver throughout my time in Brook House. She was accessible, approachable and visible. Other members of staff would come and find me regularly, as I operated an open door policy, I always carried a radio so that I was accessible to my staff and operational staff. I had a work phone, so I was always available out of hours as well. When I progressed to Senior Practice Manager, I would sometimes also work Sundays.

27. Explain your experience of being managed at Brook House. Include details of feedback, appraisals, and working relationship with your direct manager. Provide details of who your direct manager was with dates if recall them.

My direct manager was Sandra and I had a regional manager that I reported to, Kerry George. Kerry was a clinical manager but had regional responsibility. Appraisals were not annual nor regular, however they should have been. We did have occasional one to one discussions but they were very limited. If I had a problem, I would raise it. I was quite proactive and didn't need

to be managed as much as other people. I would pick up work regularly even from my line manager. Sandra was my immediate line manager on site. The Regional Manager didn't have much of an understanding of clinical and non-clinical elements to my role and were not visible on site. It was much more beneficial to have a clinical and non-clinical management line.

28. ***Set out your experience of working with other healthcare staff, in particular, whether you felt able to rely on other healthcare staff to support you in your role.***

I had a really good experience of working with other healthcare staff. Everyone had lots of different skill sets and specialities and I felt that we worked really well together as a team.

29. ***Provide a description of how clinical supervision of healthcare staff generally took place during the Relevant Period.***

This is not something I was involved in, I am aware this was sporadic.

30. ***Explain how your clinical supervision took place.***

I was non-clinical staff so didn't have clinical supervision.

31. ***Did you experience any problems with your line management or clinical supervision? If so, what?***

I didn't need much supervision so I had no problem with my non-clinical supervision. In terms of line management, we got on 90% of the time. There were sometimes challenges but nothing that was a cause for concern, they were more professional disagreements

32. ***What, if anything, could be improved?***

Things improved naturally. Staff still had one to one meetings and regular supervision however, as managers, I don't feel we had sufficient support all of the time.

Disciplinary and grievance processes

33. ***Provide details of any involvement you had in disciplinary investigations, including any investigation: (a) carried out by you as a manager; (b) carried out into your own conduct and/or (c) carried out into another member of staff, for which you were a witness.***

In relation to each example:

a. please provide approximate dates;

b. a description of the issue;

c. who was subject to the investigation;

d. what the investigation involved;

e. what the outcome of the investigation was;

f. whether any further action was taken following the disciplinary outcome;

g. whether there were any 'lessons learned', and if so, how they were disseminated and followed-up.

I carried out disciplinary investigations out as a manager but these disciplinary matters related to key breaches and door breaches for example. Security were always keen to progress such breaches to disciplinary hearings. Any disciplinary for any member of staff would be recorded on their file.

34. ***Please provide details of any involvement you had in a grievance investigation, including any grievance investigation: (a) carried out by you as a manager; (b) carried out following a grievance raised against you; (c) carried out following a grievance raised by you; and/or (d) carried out into another member of staff, for which you were a witness. In relation to each example:***

a. please provide approximate dates;

b. a description of the issue;

c. who was subject to the grievance;

d. what the investigation involved;

e. what the outcome of the investigation was:

f. whether any further action was taken following the outcome;

g. whether there were any 'lessons learned', and if so, how they were disseminated

I was aware of grievance procedures but was not involved in any.

Staffing

35. ***Describe the staffing levels in healthcare at Brook House during the Relevant Period.***

We had lots of vacancies in Brook House in terms of clinical staff. General Nurses were particularly short staffed. I don't think the centre has ever been fully recruited in terms of permanent clinical staff. There was always a large turnover of operational staff. It is not a very attractive setting for a nurse to work in and pay was an issue initially. The pay issue was resolved and nurses are paid well now in terms of NHS banding. We used to interview a candidate within 3-4 days of receiving a CV however due to the thorough clearance process, it took up to 3 months to start work at Brook House. We spent a lot of time training staff who did not stay with us for long.

36. ***In your opinion, were there, at all times, sufficient staffing resources to be able to provide adequate healthcare services to the individuals? Provide your opinion on whether the staffing levels in healthcare were of an adequate level to enable staff to perform all the***

functions of their role. If they were not, identify why not. Further, did you ever raise this at the time. Please provide details. If you did not, please explain why not.

I think the staffing levels in healthcare were of an adequate level to enable staff to perform all the functions of their role. Occasionally a member of staff would call in sick last minute but there would always be somebody there to administer medicine to the residents. We provided appropriate levels of service at all times.

37. ***What was the proportion of permanent healthcare staff to agency staff?***

At times there would be more agency staff in Brook House than permanent staff but it was usually a 50:50 split.

38. ***Were agency staff experienced at working in detention centres or a custodial environment generally?***

We had a good selection of agency staff. We regularly used two agency organisations however we stopped using one after issues with invoicing. We then approached another agency and worked with them. We had a pool of approximately eight agency nurses who we used on a regular basis. We ensured that the nurses had the relevant clearance and they would liaise with us about moving around the centre. We had some really experienced nurses who had worked in Category A prisons.

39. ***Were agency staff familiar with the systems and procedures in place at Brook House? What was the nature of training/induction provided, if any?***

All agency staff had an induction and they were given security and ACDT awareness training at the centre. They had to provide evidence to show that they had already completed personal protection training. We would give them training about how to administer medicines and how we run our centre.

40. ***Did the number of agency staff generally affect the provision of healthcare to individuals? If so, how?***

I don't think the number of agency staff affected the provision of healthcare to individuals, as they were trained to do everything our nurses could do. They worked regularly at Brook House and were familiar with our way of working. We did try to recruit some of the nurses as permanent staff

41. ***Provide your opinion on the impact that any shortages (if they existed) had on the care and treatment of individuals, in particular, whether staff were unable to offer services that they would have been able to provide if they were fully staffed (if shortages existed) and if there were delays in provision of healthcare to individuals as a result.***

A triage clinic was held every morning and residents could walk in without any appointment. Sometimes that triage clinic was pushed back if nurses were busy with an emergency response and understaffed but this was not a regular occurrence.

42. ***Provide your opinion on the impact that any staffing shortages had on healthcare staff, including morale and safety (whether perceived or actual).***

Staff shortages had a negative impact on staff morale. It always has an effect when you've got a 12 hour shift ahead and a member of staff is off sick for example. The staffing levels sometimes decided what type of day was ahead in terms of services provided.

43. ***Provide your opinion on the staffing levels of the detention staff.***

When I went out onto the wing, there always seemed to be sufficient numbers of staff. It was difficult if we required escorts to take residents out for hospital appointments. There was no upper limit on residents leaving the centre. If residents needed to attend appointments, we would ensure that they attended. Sometimes there were issues with emergency responses and staff would be moved from Tinsley House to Brook House. I thought detention staffing levels were always adequate.

44. ***Provide your opinion on the staffing levels of the activities team.***

I saw activities through the course of my time at Brook House but I would not know if they were under or over staffed.

Relationship between Healthcare and Detention Staff

45. ***Provide details of your experience of working with detention staff. In particular:***

a. ***Day to day working with the detention team in relation to the welfare of detained persons ;*** I had a good working relationship with detention staff. If a detainee came to my office and spoke to me and advised that they were feeling low, I would phone the relevant wing staff and ask someone to go and check on him. Detention staff would always do so and then provide detailed feedback about the resident.

b. Effectiveness of involvement of the detention team in use of force incidents;

I think the involvement of detention staff in use of force incidents was effective. If we had issues with a resident in terms of them having a shoulder injury for example, the nurses would tell the detention staff to be careful when using a restraint and this was always followed. Everyone in the centre had to be fit for use of force and if they weren't, this had to be highlighted to the Home Office.

c. ***Communication with detention staff about any individuals with ongoing medical needs***;

We have to be careful when sharing information regarding residents' medical needs as we did not want to breach medical in confidence rules. If we were concerned about somebody's food and fluid intake, we would ask a member of detention staff to monitor him. We would sometimes ask for them to be on more constant watch. You could share basic information and we had supported living plans for certain residents, so that would be flagged to officers.

d. Attitude of detention staff towards detained persons (provide any specific examples you are able to recall);

I did not have any concerns.

46. ***Did you experience any problems with the relationship between healthcare and detention staff? If so, what?***

There were no major problems with the relationship between healthcare and detention staff. There was no negativity. There were not any operational difficulties or pressure on resources. It was sometimes difficult explaining to detention staff that you could not disclose certain information as a result of medical in confidence. It was also difficult telling the Home Office that a person was not fit for detention.

47. ***Provide your opinion on the impact any such issues had on healthcare staff, including morale and safety (whether perceived or actual).***

I don't think staff morale was an issue, healthcare staff got on well with operational staff. I got on well with operational staff. They were always polite and we exchanged some work banter. All staff had lunch in a shared lunch room and there were no issues. If a nurse was going out on to a wing, officers would know where she was at all times. There was usually an officer in healthcare or nearby.

48. ***Provide your opinion on the impact it had on the ability of healthcare staff to fulfil their roles and to provide adequate healthcare services to individuals?***

There was no impact on the ability of healthcare staff to fulfil their roles. If a nurse wanted an officer present at a consultation for example, they would be there.

49. ***What, if anything, could be improved?***

Staffing levels could be improved and increased. When I left Brook House, they had increased and there were more staff across the centre. There also needs to be a greater understanding around the medical in confidence and detention staff need to respect it.

Relationship with Home Office

50. ***Explain your working relationship with Home Office staff, including those who worked within Brook House and those who worked externally. Include details of the level of contact that you had with them, the focus of their involvement at Brook House, your opinion on how they balanced immigration removal procedures with individual welfare. Explain your answer and please give specific details of any particular Home Office staff about whom you wish to comment.***

I had daily contact with Home Office staff on site and the occasional contact with case workers off site.

51. ***Did you experience any problems with the relationship between healthcare staff and the Home Office? If so, what?***

Overall it was a good working relationship with Home Office staff on site and they were generally supportive. Occasionally it seemed that healthcare staff's opinion was not valued when making decisions on a resident's fitness for detention, this was often with the Home Office Gatekeeper team and Detainee Escorting and Population Management Unit "DEPMU".

52. ***Provide your opinion on the impact it had on healthcare staff, including morale and safety (whether perceived or actual).***

The Home Office's decisions are final and not ours and sometimes this could cause people to feel disheartened however there was not a huge impact on staff morale. There were occasional safety concerns in terms of registration with the Care Quality Commission ("CQC"). Sandra was very passionate about her CQC registration because we were regulated by the CQC.

53. ***Provide your opinion on the impact it had on the ability of healthcare staff to fulfil their roles and to provide adequate healthcare services to individuals?***

If a new resident came in to Brook House and required constant attention or personal care, it was difficult to provide one to one care. Tinsley House would also sometimes transfer patients, which created more work.

54. ***What, if anything, could be improved?***

Healthcare could have been more involved with policies. Lots of policies such as adults and risk policies were developed very little healthcare input. We had very little say. If we thought someone was a high risk individual and was not fit for detention, it was perceived that this did not carry much weight.

Reception / Healthcare Screening / Induction

55. ***Please refer to Detainee Reception & Departures (CJS006045) and Detainee Admissions and Departures Brook House IRC (CJS006046). Please provide a description of the usual reception healthcare screening process for individuals on their arrival at Brook House. Please summarise what this involved, for example:***

a) ***How soon it was after arrival;*** the healthcare screening had to be done within 2 hours of a detainee's arrival at the Centre. This happened 99% of the time but there would have a been a few occasions when this was breached, usually when there was a large volume of admissions or if there was an operational issue on site for example if there was an emergency on site that would take priority.

b) ***Whether it was during daytime or night-time;*** We received admissions 24 hours a day so the healthcare screening could be done during the day or night.

c) ***Where it took place;*** Healthcare screenings were done in one of two clinical rooms in the detainee reception area.

d) Who carried it out (what level of healthcare professional); The healthcare screenings could be done by a Registered General Nurse or a Healthcare Assistant.

e) ***Whether the individuals had access to an interpreter if needed/requested;*** We had access to interpreters via the telephone, Language line.

f) ***Whether the individuals were given any written materials concerning healthcare in Brook House;*** The detainees were given copy of the medication in possession risk assessment we completed (if that was appropriate for that detainee), which they signed to confirm they understood how to take their medication. We also had induction leaflets, which was like a pamphlet showing opening times for healthcare, the services we provide, how to access the nurse/GP or mental health nurses. I don't think this was always given out, but it was available in different languages and the information in the leaflet was also covered in the induction given to the detainees the following day. Language line would go through the leaflet with the detainee if they needed it. An appointment would also be arranged with the GP for the next day.

g) ***Whether healthcare staff had access to any previous medical records and if so the process for obtaining them;*** Some detainees would come with medical records from another centre, some came with a paper based record for example a hospital discharge note or appointment letter, other detainees records would be provided via the computer system. Other detainees came with nothing and had all sorts of ongoing medical issues, with no paperwork and a poor understanding of their condition. We would always try to obtain access to previous medical records. Ideally those enquiries are carried out by the nurses, but healthcare assistants or the healthcare administrator also sometimes got involved in trying to get the records and on occasion I would help with this as well.

h) If an individual arrived with medication in their possession, what the process was for dealing with it; Certain medication absolutely cannot be kept as in possession medication for example mental health medication or sleeping tablets as they are highly tradeable in the Centre and some people use those kinds of medication for illicit purposes. We carry out an in possession risk assessment when the detainee arrives at the Centre to assess whether the medication is suitable for in possession and whether it is safe for the detainee to have the medication in their possession. They have to be able to demonstrate that it is medication that has been prescribed to them and that they understand how to take it. If a detainee is on an ACDT they would not be allowed to have medication in their possession as we are trying to support them to keep them safe. If medication is not named labelled in English or not labelled at all we would remove it as we don't know what it is and the GP would then review the detainee.

i) ***If an individual arrived on medication but without it in their possession, what the process was for the prescription and dispensing of appropriate medication;*** The

detainee would go to the GP who would complete a prescription. That prescription is then taken to Boots at Gatwick and is delivered to Brook House. The medication is then put into a box for that patient and is dispensed at the appropriate time. If a detainee arrived and didn't have their medication we couldn't give it to them and they would see the GP first thing the next morning. We also had a GP on call who we could check with.

j) If an individual was suffering from a diagnosed physical health condition? Physical health conditions are part of the reception healthcare screening. The action taken would depend on what the condition was. If there was a mobility issue this would be documented and we would open a Personal Emergency Evacuation Plan ("PEEP") and the person would be located appropriately in the centre. If someone had diabetes for example then an SLP would be opened. A GP appointment is booked for the following day for each detainee to be reviewed. If we felt there was a risk to the detainee or others and we needed to share that information, we would tell the detainee we needed to share it and they would be reviewed by a nurse regularly if they needed it.

k) ***If an individual was suffering from a diagnosed mental health condition?*** This would also be part of the reception healthcare screening. If an SLP was required this would be opened, if there were issues around location for example if the detainee is claustrophobic they would go onto E wing for the first few nights where it is quieter. Any referral needed to an RMN would be made or a GP appointment set up.

l) ***If an individual was deemed to be vulnerable?*** We can pick up certain vulnerabilities during the reception healthcare screening process for example if there are learning difficulties this can often be obvious from the outset and an SLP would be opened. The template for the reception healthcare screening covers all eventualities, self-harm lifestyle, whether the person smokes or takes drugs, it also asks about sexual orientation which feeds into safeguarding, and sexual health screening is put in place if needed.

m) ***If an individual was assessed as having a substance misuse issue?*** This is part of the reception healthcare screening. If a detainee said they were on a programme we would do a drugs test if needed which would be supervised by an officer. The GP is informed and they are seen the next day or given overnight support.

n) If an individual was assessed as being at risk of self-harm or suicide? If we felt a detainee was at risk we would open an ACDT immediately. The person doing the reception health screen asks questions about self-harm and suicide as part of screening process.

o) Where the individuals were accommodated for the first night or nights of their stay and what access there was to healthcare staff and services; Detainees are located on the induction wing for the first night in the Centre. If they needed to go onto E wing for different reasons then they would be accommodated there. If they had not had their induction a nurse would go to their room or an officer would bring them to healthcare if they needed to see healthcare. E wing no access to centre unless signed off for access so healthcare would attend E wing.

p) ***What provision was there for individuals to healthcare staff to follow up following their first night in detention?*** After the first night in detention, each detainee has an appointment with the GP and they have an open access clinic in healthcare every morning. Emergency care is also available.

56. ***If this usual process was variable, describe how it differed from the description you have provided, how often, why, and in what way.***

The variables were:

- Whether a detainee was seen in 2 hours would depend on the volume of arrivals.
- The reception healthcare screening may have taken place in a different location if there was an ongoing issue in reception but we would call the Home Office and stop arrivals if we needed to.
- If there was a crisis or a safety issue and we couldn't get an interpreter we would get a staff member or friend who could interpret to get the detainee through that emergency situation and then follow up with a formal interpreter.
- Getting hold of medical records and medication was hit and miss.
- If there were no beds on the induction wing (B wing) the detainee would go to another wing, but this is not something healthcare were involved in.

Healthcare Facilities and Equipment

57. ***A description of the physical environment of healthcare in Brook House. What facilities were there for the provision of the following in Brook House:***

a) ***Primary care services (physical health services);***

In relation to primary care services, there were two reception rooms on the ground floor for new arrivals. These rooms were also used for external visits also used for our dentist who visited the premises and our visiting optician. In main healthcare upstairs there were two clinical rooms, one waiting room and one pharmacy hatch.

b) ***Mental health services.***

There was one mental health room located on the visits corridor and the visits room was used for some sessions. It was not a dedicated healthcare room and would often be used for other things as well.

58. ***Did healthcare have the physical resources to deal with the health conditions with which individuals presented?***

Healthcare had all of the equipment that we needed and if we needed more or any updated equipment it was something we could go to G4S for. We needed more clinical rooms and more

office space to provide a better service. We were limited in services we could provide because of the room space. The rooms we did have were more consultation rooms than clinical rooms.

59. ***Did healthcare have the equipment to deal with the health conditions with which individuals presented?***

I don't think there were many occasions when we didn't have the right equipment. If we had first response emergencies then more equipment was sometimes required.

60. ***What problems, if any, were there with the physical environment regarding the provision of healthcare to individuals?***

I cannot recall any problems with the physical environment regarding the provision of healthcare to individuals. We had annual equipment checks and anything that was not fit for use, we would replace. Anything not up to standards would be taken out of service. I don't recall any equipment failing when required urgently.

61. ***What problems, if any, were there with equipment regarding the provision of healthcare to individuals?***

A lot of improvements were made whilst I was working at G4S. The space we had used to be rather unfriendly, so we brought in a sofa. This made it much more 'counselling like.'

62. ***What if anything, could be improved?***

We were short on space and we could have benefitted from more rooms. Healthcare also needed to have the correct flooring installed – the flooring on site was not of a clinical standard

Access to Healthcare

63. ***A description of what healthcare services were provided to individuals in Brook House. In particular, please describe the provision for:***

i) ***Primary care (physical health) services;***

When new residents arrived at Brook House, they would go through reception screening. New residents would be offered a GP appointment within 24 hours and encouraged to attend. There was a medication clinic in the morning and a walk-in surgery where detainees could attend anytime between half 9 and half 11. There would be further medication clinics at lunchtime and in the evening. Residents would then be triaged and care would be applied where appropriate. The GP would be at Brook House every afternoon, including weekends. The nurses would also do chronic disease clinics in the afternoons.

ii) ***Mental health services;***

Mental health nurses would be on site all day. They would offer talking therapies, group sessions and there would also be a psychiatrist who visited once a week.

64. ***How would an individual access healthcare? What was the process for an individual to be able to see a:***

i) Nurse;

If residents had already been inducted in the centre for more than 24 hours, they could attend the walk in clinic between 9:30-11:30 every morning. Any other basis would be an emergency basis.

ii) ***GP;*** In order for residents to see a GP, they would need to first be seen and assessed by a nurse and referred to the GP for an appointment.

iii) Mental health nurse;

If residents required an appointment with a mental health nurse, they would first have to see one of the general nurses to see if they could assist them first. If they were unable to help, the resident would be referred on to a mental health nurse

iv) ***Psychiatrist/psychologist etc?*** Residents would need a referral from a mental health nurse to see the psychiatrist. Even for a brief assessments, a referral would be required. We did not use psychologists much at Brook House.

65. ***What were the problems, if any, in individuals accessing healthcare?***

There were sometimes waiting lists for residents to access certain types of healthcare, which caused delays. The waiting list was large in terms of dentistry. There were no dental suites in Brook House so any residents who required dental treatment would have to leave the centre and go to East Surrey Hospital to see an emergency dentist. Our dental service was not ideal for our patients and did not always meet expectation. In terms of our contractual obligations these were met.

66. ***Were there delays in individuals being able to access healthcare? If so, what was the cause of any delays?***

It was rare that there were delays in accessing healthcare. Where there were delays this was due to Centre operational reasons, for example if there was an emergency, or staffing issues if someone was absent from work at short notice due to sickness. Other delays could be if we had external people coming, for example the dentist, and they were sick, we wouldn't have someone who could just replace them straightaway. The volume of referrals could also cause a bit of a delay. There weren't regular delays, access was pretty good. We used to compare the waiting times against the waiting time in the community and share that with people.

67. ***What, if anything, could be improved?***

More space in healthcare would have been beneficial. Healthcare was generally understaffed and whilst we were always able to provide a service, this would sometimes be delayed due to not having enough staff on shift.

Detained Persons

68. Provide your views on what the most significant health problems of the detained person population were throughout your employment, focussing on the immediately before, during and after the Relevant period.

Most of our residents were young fit men but we had a proportion that were not. Lots of residents did not access healthcare services outside of Brook House. Some residents had not received dental care or any care before entering Brook House. The Chinese population often had dental issues and gastric issues whilst some African men suffered with blood pressure issues. As the conditions suffered with were so vast, it is difficult to say what the most significant was. Mental health was very challenging to manage. People had personality disorders and were suffering with low moods regularly – often leading to self harm.

69. What are the challenges that healthcare staff face in managing those health conditions in Brook House?

Brook House was not a mental health hospital therefore we could not put someone on 24 hour mental healthcare monitoring, as we did not have the facilities, however on occasions we were required to with the support of officers

Interpreters

70. Describe your experience of the use of interpreters in healthcare at Brook House.

We used interpreters a lot at Brook House. We had a telephone service that we used to contact interpreters. It was very hit and miss. Sometimes an interpreter could be contacted within 10 minutes and other times you would wait an hour. Sometimes the service was unprofessional and interpreters would be eating whilst speaking with us and the residents. These problems existed in 2017 and continued throughout my time at Brook House.

71. Were interpreters readily available when needed?

Interpreters were not always available when needed. The service was always there but you could not guarantee you would get an interpreter when you required one.

72. What were the problems, if any, with obtaining interpreters for individuals?

Along with access, it was sometimes difficult to obtain all of the information from interpreters. We would sometimes have to prompt them and ask if they had relayed their whole conversation, as their answers would often seem quite short compared to the length of time they had been speaking to the resident.

73. How did this impact upon the adequacy of the provision of healthcare to individuals in Brook House?

These issues would make that assessment very challenging. We would use photo cards, pictures and diagrams.

Supported Living Plan

74. What was the purpose of a Supported Living Plan (SLP)?

The purpose of an SLP was to make an individual's time at Brook House as supportive as possible.

75. ***In what circumstances would a detained person have a SLP?***

If an individual had a disability or was on crutches for example, the SLP would ensure that they were placed in a suitable location. If someone was hard of hearing, an SLP would ensure that they had someone in their room. The SLPs made everyone in the centre aware that this particular individual required more assistance. An SLP could be long term or short term and they were reviewed regularly. They were only closed when everyone, both staff and the resident, agreed they should be.

76. What was healthcare staff's role in a detained person's SLP?

Healthcare staff would open the SLP and would schedule regular reviews of the SLP. The reviews would take place with the resident and we would be in constant communication with them.

Complaints

77. What was the complaints process if an individual had a complaint about healthcare?

Residents could complain directly to healthcare either verbally or in writing. Residents could complain to NHS complaints, Home Office or to Brook House directly. They could complete a DCF9 form to lodge a complaint or they could simply write it on a scrap of paper. There were complaints boxes around the wing for complaints to be placed into.

78. Explain your experience of the complaints process, including, in particular:

i) Any examples in which you received a complaint and referred it on for investigation;

If we received a complaint, we would write to the detainee who lodged the complaint. We would look at referrals, look at their medication and decide whether it was issued appropriately. We would then write a response to the complaint and Sandra would read it before it was sent out. Senior Nurses also began responding to complaints in late 2017 early 2018.

ii) Any examples in which you were involved in an investigation, either conducted by G4S Healthcare or the Professional Standards Unit (PSU), in relation to a complaint made against you or another member of staff.

PSU requested medical notes and requested statements from staff. We would give them the information they requested, as it was not overly confidential. I don't think I

have ever referred any complaints to PSU. If the complaint was about multiple services, I would refer the relevant part of the complaint on to the wing staff or office manager etc. If the complaint was of a clinical nature I would ensure that 'clinical oversight' was included in the response.

Please include what happened, any investigation process, the outcome and any lessons learned. If there were lessons learned, whether they were implemented and effective.

E Wing

79. Please refer to E Wing Policy (CJS006043). Describe the nature of the detained persons who were accommodated on E Wing.

E wing housed people who needed a lot of support. This included anyone who was sectioned, or who had ongoing serious mental health issues but had not been sectioned; people with major behavioural issues; detainees who were being bullied or the bully depending on who was the best person to move. We also had two substance misuse rooms, so could have people detoxing on E wing and would move people who needed to isolate due to TB or chicken pox, or detainees on constant supervision onto E wing. A detainee with serious mobility issues might be housed on E wing as it was all on one level and had everything they would need. Detainees who had an impending removal direction or transfer could be located on E wing or CSU. It was a really mixed wing and was very difficult to manage.

80. What was the purpose of accommodating an individual on E Wing?

The purpose of E wing was to provide extra support to detainees who were vulnerable, infectious, had behavioural issues or were subject to impending removal. This was my understanding.

81. What was healthcare's role in the management of individuals on E Wing?

A nurse would go to E wing in the morning to do a medication round and the GP did a round in the afternoon. We also provided medication rounds in the afternoon and evening. If a detainee was on constant observations healthcare would go and check people. Healthcare would regularly go and see detainees who were withdrawing from substances or who were refusing food and fluid refusal.

82. Please refer to Removal from Association (CJS006040) and Temporary Confinement (CJS006041). What are the criteria for moving an individual to the Care and Separation Unit (CSU)?

These two policies are Care and Justice policies, not healthcare policies and I am not familiar with them.

C&R could be used around rule 40/42, and could be used for behavioural issues or to facilitate removal. From a healthcare perspective C&R may be used if a detainee will not follow

healthcare advice for example if they had active TB and refused to isolate as this is a safety risk to other detainees, however this was uncommon

83. What was healthcare's role in the management of individuals on the CSU?

Anyone in CSU usually on Rule 40/2. Healthcare would have to assess whether the detainee was fit to be held in isolation on CSU and complete paperwork to confirm this. This was a template style form, also completed by the officers, where healthcare would complete their part of the form. If the detainee was not safe to be in isolation healthcare would have to say so and find a workaround, this could be that they are on CSU with an open door and try to engage them and try to integrate them. Healthcare also did a daily duty round to check on detainees in CSU.

Medication

84. A description of the process for management of medication for an individual who had been prescribed medication that could remain in their possession.

If a resident had been prescribed medication that could remain in their possession, the individual would first be risk assessed to confirm suitability e.g. can they read English and read the packaging. We would also have to ensure that they were not at any risk of overdosing. Nurses would do an in possession risk assessment on arrival. If the medication was a tradeable medication, it would not be kept in their possession. Anti-depressants were not in possession either. Ibuprofen or 'over the counter' style medication would be in possession if it was determined that the resident was fit to have it.

85. If an individual was prescribed medication that could not remain in their possession what was the process for obtaining required medication?

There was a medication round 3 times a day. Residents would attend healthcare between the allotted times. They would present their ID at the hatch, the ID was checked against their medication and the medication was taken at the hatch. If a resident required their medication more than 3 times a day, healthcare staff would take it to them or a suitable time for the resident to attend the medical hatch to take it would be arranged.

86. What were the problems, if any, in the management of detained persons' medication?

There were occasional problems with the delivery of the residents' medication. We had a good relationship with Boots. If a doctor decided they did not wish to continue medication for a resident and the resident did not agree, there may be issues. There were also occasional issues around queuing for medication, as some residents would become impatient.

87. What, if anything, could be improved?

Having an officer present at every medication round would be beneficial. This has now improved is my understanding within the new contract. Storage space could also have been improved but overall the medication clinics went quite smoothly. The service that Boots

provided could have been improved in relation to emergency deliveries, as these were not always delivered when requested.

Drug / alcohol misuse

88. ***Please refer to the Drug and Alcohol Strategy (CJS006083). A description of the process for the identification and assessment of individuals with substance misuse issues on their arrival in reception at Brook House.***

This was part of the reception healthcare screening. Healthcare staff may or may not be on notice of a substance misuse issue. We would test the detainee if we suspect or they declare or there is evidence of substance misuse. Sometimes this is on their records or their behaviour might indicate they have taken a substance, or there could be something in their property to confirm substance misuse.

89. ***What treatment was available at Brook House for individuals identified as having a substance misuse issue?***

We worked with the Forward Trust to provide a substance misuse programme. Healthcare provided the clinical element and the Forward Trust did the psychosocial part of the programme.

We also had two detox beds on E wing.

90. ***What substance misuse services were available in Brook House during the Relevant Period?***

I think the Forward Trust was available in 2017 but may not have been fully up and running. Before Forward Trust we didn't have a formal substance misuse programme so we couldn't take anyone with substance misuse issues and they would be transferred to an alternative Centre.

91. ***Were the services and treatment available for individuals with substance misuse issues adequate in your view?***

I think they were very good. The Forward Trust were really supportive. The clinical service was good, and they had good access to the GP with regular planned reviews.

92. ***What, if anything, could be improved?***

The only thing I can think of is more education around illicit drugs for example Spice would have been good for officers, staff and detainees.

93. ***A description of the level and nature of substance misuse amongst individuals in Brook House during the Relevant Period.***

In 2017 we had a low level of methadone users initially. Drug use in the Centre went up and down and I can't remember whether 2017 is when we had issues with Spice in the Centre. Spice was new around that period of time and it was very different and difficult to manage and

treat. The healthcare team went back to basics, assessing and managing detainees and doing a lot of airway management. It was very challenging. I think it was Christmas or Boxing Day that year when we had 26 emergency calls in one afternoon, which was an exceptional day. Usually we might have a couple of emergency calls a day but Spice really did cause a lot of problems.

94. ***What was healthcare staff's role in the management of individuals who were using drugs or alcohol whilst in Brook House?***

Healthcare staff assessed detainees, and provided support, treatment and medication alongside trying to understand what was going on for the detainee and educating them as well.

95. ***What was your experience of attending to individuals who were intoxicated by drugs or alcohol in Brook House?***

I would quite often attend with the nurses if they were busy. I would grab the emergency bag and go with the nurse to hand over any equipment they needed as there could be a lot to carry with the bag an oxygen cylinder. I got used to what to expect. If it was Spice then potentially the detainee might be fitting, vomiting or being aggressive. The emergency call could be absolutely anything, but we could get a rough idea of what the issue might be if we had an idea of the trend of calls from that day or the day before.

96. ***Did you have any concerns about the appropriateness of healthcare staff's management of individuals who were intoxicated?***

No.

97. ***Did you have any concerns about the appropriateness of detention staff management of individuals who were intoxicated?***

I didn't have any concerns. I noticed that detention staff often assumed a detainee had taken Spice when the symptoms could be because of many other health issues but this wasn't a concern as such.

98. ***If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?***

I didn't have concerns that I felt needed to be raised. If I had concerns I would have raised them with the Oscar One on duty that day.

Mental Health

99. ***A description of your experience of the management of individuals who suffered from mental health conditions.***

There were a lot of mental health conditions that residents suffered from in Brook House. Mental health nurses were very good and they had a vast level of experience. The psychiatry team who were sub-contracted were also very good. Some of the psychiatrists weren't always aware

of where they were going to be working and what the environment was like in Brook House. It was managed appropriately to the level we physically could. Operational staff relied heavily on healthcare to provide guidance and support. The Home Office were quite supportive and always listened to our comments and progressed any issues. The amount of bed space for mental health patients was very challenging at times. I found that most officers treated residents suffering from mental health conditions with respect and dignity and went above and beyond to support them. Other officers did not know what to do. I don't think they could be criticised for this, as it was down to a lack of training. More training was definitely needed in relation to mental health and how to deal with it.

100. Did you have any concerns about the appropriateness of healthcare staff's management of individuals who suffered from mental health conditions?

I don't recall having any concerns with any members of healthcare staff specifically. I think they always dealt with residents suffering with mental health efficiently and professionally. GPs were always there to assess residents daily on the wing.

101. Did you have any concerns about the appropriateness of detention staff management of individuals who suffered from mental health conditions?

I did not have any concerns about the appropriateness of detention staff's management of individuals suffering from mental health conditions. I think they always dealt with them appropriately in line with their code of conduct. I may have told members of staff in the past to bear in mind that certain residents were unwell and therefore not in control of their attitudes and behaviour. It wasn't regularly that I had to remind people of that and when I did, staff immediately apologised. It was just due to gaps in knowledge. I never heard any derogatory comments or saw any inappropriate behaviour.

102. If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?

If I had any concerns, I would have raised them with the member of staff individually and then escalated the concerns to their manager.

Rule 35 reports

103. If you were involved in writing Rule 35 reports, please set out your experience of doing so.

Rule 35 reports can only be written by a GP. I have never written a Rule 35 report.

104. Set out your understanding of the purpose of a Rule 35 report?

There were 3 sections to Rule 35 reports, one in relation to victims of torture, Rule 35(2) was in relation to suitability for detention and one was in relation to medical suitability and mental health issues.

105. Describe the approach taken when assessing an individual in accordance with Rule 35 and recording that assessment.

All of the health issues had to be documented by a GP, they would assess the detainee on suitability and document it. That would then be submitted to Home Office for consideration and would be dealt with within 72 hours and a formal response would be sent back. The response would either confirm that the resident should remain in detention or would initiate release or they would request more info.

106. What criteria are applied to identify suitability for ongoing detention?

This was decided by the Home Office but I think in relation to release, there must be an element of no risk to the public. If a resident had absconded or attempted to abscond in the past then they would be less likely to be released.

107. What is the nature of an assessment of an individual for the purposes of a Rule 35 report? How is the assessment carried out?

All assessments for Rule 35 reports are carried out face to face with the GP. There would be a discussion between the GP and the resident and then an examination as required. There is a template for the GP to fill out when conducting Rule 35 assessments. There was also a body mapping exercise on there but this may have changed to being non-mandatory.

108. Who was responsible for ensuring compliance with clinical standards and the effective implementation of the Rules 33-35 of the Detention Centre Rules (DCR) safeguards?

The GP completing the assessment and also Sandra as Head of Healthcare.

109. What are the challenges you face or faced in carrying out Rule 35 assessments? What, if any, problems were there?

Rule 35 assessments are very complex and some of the content discussed was quite challenging, I think GPs would agree. It is also hard to work out whether the resident's version of events is the truth. There sometimes would be no scarring or evidence therefore it was difficult to know whether they were truthful accounts. Waiting times for Rule 35 assessments increased occasionally when certain populations were in the centre. Most of the appointments were 45 minutes and the documentation was quite lengthy.

110. Did you have any concerns about the process of assessment and writing of Rule 35 reports?

I did not have any concerns about the process of assessment and writing of Rule 35 reports. I had some concerns that the people reviewing the Rule 35 reports were not clinicians. It is not appropriate for a non-clinician to understand the terminology and make a judgement, especially in relation to mental health conditions. This was an issue that was often discussed.

111. If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?

Rule 35 concerns were always raised with the centre and the on-site Home Office staff. We also raised concerns with G4S health regional managers and the clinical governors lead who was a GP as well, she was quite often involved in complex cases.

112. What, if anything could be improved?

In terms of improvements, it would be beneficial for nurses to also carry out Rule 35 assessments. Nurses often have more time and can build up a relationship with residents and could definitely provide an answer on whether an individual was not fit for detention. More training around Rule 35 reports should also be implemented. There was never formal training for clinicians. It was always difficult for them to make decisions.

ACDT and self-harm risk management

113. Please refer to the following documents / policies:

i) Suicide Prevention and Self-harm Management (CJS006380);

ii) Safeguarding Policy (CJS006379);

iii) Guidance for staff managing detainees on Constant Observations (CJS006378);

iv) Management of Adults at Risk in Immigration Detention (CJS000731). A description of your role and involvement, if any, within the ACDT process

My involvement was very limited. I attended one or two reviews as a healthcare representative if needed.

114. A description of how individuals who were at risk of self-harm or suicide were identified and assessed.

This was part of the healthcare screening. They could also be identified in a GP appointment or could be just walking down the corridor and a member of staff might notice if someone was acting in a concerning way. Anyone can open an ACDT and highlight any concerns to a manager to get an ACDT opened.

115. What role did healthcare staff play in the identification and assessment of detained persons who were at risk of self-harm or suicide?

Healthcare staff played exactly the same role as anyone else. They would look at all elements, physical and mental wellbeing, any trigger points that might indicate a risk of self-harm or suicide.

116. What role did healthcare staff play in the management of individuals who were at risk of self-harm or suicide?

Predominantly an RMN or learning disability nurse attended ACDT reviews. If they were really concerned about someone they would potentially go and see them at random times of the day to check on them. We would also liaise with the chaplaincy team to provide support.

117. Did you have any concerns about the appropriateness of healthcare staff's management of individuals who were at risk of self-harm or suicide?

No

118. Did you have any concerns about the appropriateness of detention staff management of individuals who were at risk of self-harm or suicide?

I don't recall any concerns. I think I raised one incident where I felt the constant supervision being provided was not good enough as the member of staff was not always focused on the detainee.

119. If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?

I raised the incident I've referred to at 118 with the wing manager and they went and spoke to the officer who I think was a new member of staff and explained how to do constant observations and asked if they needed a break. It is hard mentally to do constant observations.

ACDT

120. What do you understand the purpose of an ACDT document to be?

To raise concerns about a detainee's self-harm or suicide risk and have those concerns formally raised, and support provided.

121. When would an ACDT document be opened in relation to an individual?

An ACDT assessment would be done by an assessor, not healthcare staff. Anyone can raise a concern and ask for an ACDT to be opened, this is done at the point of a concern or declaration of an intention to self-harm. I could start the process to open it, and would then get a manager / assessor who would carry out a full assessment of the detainee.

122. What was the threshold for opening an ACDT document?

The threshold of opening an ACDT document is up to the person doing the assessment. An ACDT can be opened even if it is only opened for a few hours to investigate and deal with any issues to support the detainee or it can be open for longer. It is not a tick box exercise.

123. What was the process for opening an ACDT document?

The assessor goes through the ACDT book with the person and does a full assessment.

124. How would an individual be managed on an ACDT document?

The detainee could be on a level of observations or might be moved to a different wing, or into a room to share or a room on their own depending on the person's individual issues.

125. What was the review process for individuals with an open ACDT document?

There would be structured multi disciplinary ("MDT") reviews. I can't remember how often the reviews had to be but I know they had to be structured and were allocated to the manager on the day. A healthcare representative attended the reviews.

126. When would an ACDT document be closed in relation to an individual?

An ACDT would only be closed when the risk had reduced significantly or gone. It would be kept open as a precaution if needed.

127. How could an ACDT be challenged?

We probably could have challenged an ACDT but I have never seen it done. I can't think of any occasions when an officer or healthcare would challenge it.

128. What role did healthcare staff play in the management of individuals on an ACDT document?

Healthcare staff attended MDT reviews. One of the RMNs may touch base with them, or they might have ongoing medical needs or family issues and need support with that. It would all depend on the individual's situation and it would all be documented in the ACDT book.

129. What problems were there, if any, with the process of managing individuals on ACDT documents?

Not that I experienced no.

130. What, if anything, could be improved?

There was an issue with communicating timings of ACDT review meetings as healthcare would be contacted and a nurse would be requested immediately. This was just a communication issue and has now been resolved as there is a spreadsheet timetable in place showing when the reviews are and this is covered in the daily handover sheet.

131. The inquiry understands that there were weekly healthcare Multi-Disciplinary Team (MDT) meetings held attended by the mental health team, medical team (GP) and healthcare administration team. Did you attend these meetings? What was their purpose and what was discussed?

Healthcare did attend these meetings. They were planned weekly but didn't always happen if there weren't any patients who needed to be discussed or due to availability of staff. We discussed patients we had concerns about so patients in mental health crisis for example, or anyone needing more support so had come onto healthcare's radar. I think I actually set the

meeting up initially as I felt it was needed as there was lots of cross over between the mental and physical healthcare teams and it was a forum to share information. It did work well.

132. The Inquiry understands that there were Safer Community Meetings and Adults at Risk (AAR) Meetings held in Brook House attended by detention staff. Did healthcare staff attend these meetings? If not, why not?

Yes we attended. I attended these meetings regularly as did Sandra Calver.

133. Were there any mechanisms in place to offer support or counselling to individuals who had witnessed a violent or distressing event at Brook House?

Yes chaplaincy or the care team or the mental health team would touch base with individuals who had witnessed a violent event.

Food and Fluid Refusal

134. Please refer to the Refer to Food & Fluid policy (CJS006084). What was healthcare staff's role in assessing an individual who was refusing food or fluids?

This food and fluid policy is not the policy that we followed in healthcare. I don't remember seeing this document before. We followed the Home Office Food and Fluid policy.

If a detainee was refusing food and fluid this would be highlighted on the food and fluid log and healthcare would go and do an assessment of the person. They look at the person's weight, whether their lips are moist, whether there is evidence of food and drink consumption, and whether their skin is intact. They do a full assessment and then BRAG rate them. Green means the person is fine and well, amber is the person's wellbeing has changed but they are ok, red means the person is not in good shape, black means the person needs to be in hospital as they are at risk of becoming very unwell. Healthcare are involved from the very beginning if there is no evidence of food or fluid intake for 24 hours. We check the person until they have eaten two consecutive meals, however a meal did not include breakfast which was always a bugbear of mine as some people only ate breakfast and then snacked.

135. What was healthcare staff's role in managing an individual who was refusing food or fluids?

As I have described at 134 above regular checks are made and healthcare would highlight their concerns to the GP or the Centre. If someone was becoming unwell they would ask them to be monitored more closely by detention staff so they would take food to their room so it is accessible and try to get as much information as possible.

136. What documentation did healthcare staff need to complete where an individual was refusing food or fluids?

We completed the forms that were with the Home Office policy and document them on the detainees notes and scan them in along with the BRAG rating.

137. Have you had experience of individuals refusing food or fluids? If so, please describe your experience.

I have had experience of a whole range of detainees refusing food or fluids. We have had people who were food and fluid refusals but they didn't like the Centre meals so had their own food in their room and used the cultural kitchen to make their own meals. If they are making their own meals they are still classed as a refusal and we still need to see them every day. We might see them walking around eating, so we make notes of what we see them eating so there is evidence of what they are eating.

We also have some people who would stop eating and drinking for a couple of days. Others would continue not eating or drinking for longer and get to day 10. By that stage the GP is going in to have a discussion with the person about advanced directives and explains what is happening to the body and what will happen if they don't start to eat and drink. If they say they will start to eat and drink the GP has to put a refeeding programme in place to reintroduce food slowly. If the person doesn't start to eat or drink again then ultimately we have to send them to hospital.

I remember one very bad case where the detainee was developing cracked skin and at risk getting bed sores. When we asked him why he was not eating he said he wanted to be released and we had to advise the Home Office that he would die if he was not released. I think he was released and taken out by ambulance. Quite often detainees would refuse observations and we would have to respect that. Nurses would still attend and make an assessment on what they could see and smell. We would often send multiple nurses, the doctor, Sandra to try to get as much information as possible and often one person would get somewhere with the detainee and he would let them do some checks. If there was a particular officer the detainee got on well with we would get them involved too. Everything we did was in the best interest of the detainee.

138. Did you have any concerns about the appropriateness of the management of individuals who refused food or fluids? If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?

My only concern was with process. I was concerned about using force on someone who needed to be moved to E wing to be closely monitored. I would question whether it is right to use force on someone who doesn't want to go to E wing to be monitored.

Use of Force

139. Please refer to the Violence Reduction Strategy (CJS000721). What role do healthcare staff play in the use of force on a detained person individual?

The violence reduction strategy is not a document healthcare used. Healthcare would need to go to the use of force ("UOF") briefing for a planned UOF. They would brief the operational staff on any concerns they had e.g. this detainee has asthma please be careful keep their airways clear. Everyone in the Centre needed to be fit for UOF. There were occasions where we said

a particular person can't have force used on them. Healthcare attended the UOF incident and the debrief and complete the use of force paperwork to record what they witnessed and record any injuries. A nurse goes to assess the detainee shortly after the incident.

140. In what circumstances is it permitted to use force on an individual?

To protect yourself, where it is a planned UOF there has to be a reason to use force. Officers used force if there was a fight or if someone was being removed.

141. What records are required to be completed by healthcare staff following a use of force against an individual?

There is a UOF form, officers had to get it signed by the Home Office giving their approval. An F213 form is completed recording the UOF, healthcare would complete a page of that form. Officers do the UOF paperwork and statements record any actions.

142. What follow up is carried out by healthcare staff on an detained person following a use of force?

Healthcare check the detainee shortly after the UOF incident. If there is any injury they assess it and risk assess how quickly they could assess that injury. Depending on the detainee's state of mind, they might have to do a through the door assessment, or have officers there as support.

143. Have you ever been involved in the use of force on an individual? If so, please give details. What documentation did you complete afterwards?

I have never used force myself.

I have attended planned UOF incidents usually as bag carrier. Sometimes I have completed a witness statement but ultimately it is the nurse who would complete the F213 as they did the assessment during the incident.

144. Have you ever witnessed the use of force on a detained person? If so, please give details. What documentation did you complete afterwards?

I regularly witnessed UOF incidents as I have described at 143. I attended fewer UOF incidents post Panorama, but if I was needed I would attend to support the healthcare team.

145. Did you have any concerns about the appropriateness of the use of force on the individual? If so, did you raise any concerns? If so, who did you raise concerns with? If you did not do so, why not?

I didn't have concerns about any UOF I witnessed. They were all very challenging. The only issue I would have is around timings as sometimes officers in full PPE gear and nurses would be left standing around for 2 hours waiting for people to be collected. This was a waste of nurses time and was stressful for everyone involved.

The Panorama Programme

The Inquiry's website has a link to a YouTube channel which has a BBC Panorama programme available to view for free (BBC Panorama - "Undercover: Britain's Immigration Secrets" - YouTube). If you have not already watched the programme, the Inquiry would ask that you do so and consider the following.

146. Confirmation as to whether you worked with Callum Tulley (the BBC undercover reporter). If you did, please set out details of when you worked with him.

I knew Callum Tulley. He was employed by G4S at the same time as me. I spoke to him in the corridors but never worked closely with him.

147. Whether you appear in the programme. If you do, please confirm the timings on the footage where you appear. It would be helpful if you are able to provide a photograph or description of yourself so that the Inquiry is able easily to identify you.

I do not appear in the Panorama programme.

148. Your opinion on the impact that the Panorama programme (which aired on 4 September 2017) had on staff morale.

Staff morale following the Panorama programme was awful. It was very low. Staff members were in shock. I don't think people could believe it had happened. I think people were shocked that someone would bring a camera into the centre and people were also shocked at the treatment of residents. It was a breach of policy, a breach of trust and a breach of the Official Secrets Act that we all had to sign. We were horrified at the treatment and to see operational and clinical colleagues acting in the way they did, especially a senior colleague in a clinical role. My relationship did not change with other members of staff, we all carried on doing our jobs. There was more scrutiny and more challenge at senior levels following the Panorama documentary. There was a lot of scrutiny to ensure that things were being done properly. Staff members were more suspicious of everyone and people were more wary of who was in a room with them. People were a lot more aware of their surroundings.

149. To the extent that you are aware of individuals seeing or become aware of the Panorama programme (e.g. the media), your opinion on the impact that the Panorama programme had on individuals.

Following the Panorama programme, residents were shocked and had a real lack of understanding as to what had happened. All of the staff then began being tarred with the same brush e.g. all officers were rude, all healthcare staff did not care. I think many residents were upset at the thought of staff letting this treatment happen. Staff were trying to work with residents to reassure them that they were in a safe environment.

150. During the programme, one detained person says that they are underage for detention.

151. ***Whether you were involved in this (or any other age dispute) case. An explanation of the process to be followed.***

From memory, I think I was briefly involved in the age dispute documented on the Panorama programme. If someone declared they were underage, the duty officer needed to be notified immediately. The underage resident would then be moved from their location in the centre to E Wing as a safety precaution or transferred to Tinsley House. They would also be flagged to Home Office. Social services would then be contacted and age assessments would be carried out. This process was very much led by the detention team but healthcare would be involved in making sure the detainee was healthy.

152. ***Whether there were any changes at Brook House following the Panorama programme and your opinion on whether they were effective. If they were not, your opinion on what should have been done to create effective change.***

There were so many changes in Brook House following the Panorama documentary. I don't recall any that were not effective. There were enhanced precautions and checking processes and enhanced awareness of attitudes. People were more aware of the "speak out" procedure, which was a confidential telephone number that staff could call to report any concerns, and there was enhanced due diligence of documents. There were lots of group sessions and lots of training. There was a huge overload of information and change throughout Brook House and the majority had positive effects. A monthly use of force meeting was introduced where we would review use of force and go through footage and documentation. I don't think briefings in terms of use of force changed, they were all videoed and bodycams were introduced for officers.

Specific Individuals

153. ***The following individuals who worked at Brook House were either investigated, disciplined, dismissed or left following the Panorama programme:***

In relation to each of these individuals, set out the following:

i. ***Whether you worked with these individuals. If so, provide details of when you worked together, your working relationship and your opinion of them in a professional capacity. If you had concerns about their personal views/behaviours and that this impacted on their care of individuals, please set these out.***

ii. ***Whether you witnessed them use derogatory, offensive and/or insensitive remarks about individuals. If so, provide details of what they said, the reaction of the individual, what you did (if anything) and the outcome.***

iii. ***Whether you witnessed any incidents of verbal abuse. If so, provide details of what they said, the reaction of the individual, what you did (if anything) and the outcome.***

*iv. **Whether you witnessed any incidents of physical abuse. If so, provide details of what they said, the reaction of the individual, what you did (if anything) and the outcome.***

a. ***Nathan Ring*** I worked with Nathan quite a lot. He was a custodial manager at the time, so we had quite close contact. I didn't have any concerns about him and I was surprised at the footage.

b. ***Steve Webb*** I worked with Steve once or twice. He was a manager (DCM) and he was predominantly based at Tinsley House not Brook House. I would not say I worked closely with him at all.

c. ***Chris Donnelly*** Chris and I worked together a lot. We had a good relationship. Chris was very supportive to healthcare and he dealt with really challenging individuals. I thought he was a decent officer and he led the operational team well.

d. ***Kalvin Sanders*** I don't know this person.

e. ***Derek Murphy*** Derek was a DCO and was based on E-Wing predominantly. He had previous experience working in secure settings. I worked on shifts with him and had numerous conversations with him about residents. I never had any concerns regarding his behaviour.

f. ***John Connolly*** John was a DCO. I believe he was based in Tinsley House for a lot of his time and eventually moved up to Brook House. John was a control and restraint trainer. He was an older gentleman and had older generation views. He was pleasant to work with but I think had some questionable, outdated views but nothing that needed to be reported at the time.

g. ***Dave Webb*** Dave was a DCO on E-Wing. I had limited engagement with him. I had no concerns regarding his behaviour or attitude.

h. ***Clayton Fraser*** I don't know this person, however I know the name.

i. ***Charles Frances*** Charles was Professional in his conduct. He would flag any residents that he was concerned about to us. He had a good eye for issues with residents and would raise any concerns face to face and keep us informed on how the issues had progressed.

j. ***Aaron Stokes*** I knew this officer before he worked at Brook House. I never would have expected that type of behaviour from him. I was shocked at what I saw on the Panorama footage.

k. ***Mark Earl*** I don't know this person.

l. ***Slim Bassoud*** I worked with Slim during my time at Brook House. He was always quite quiet and always really polite and helpful. He came across as really respectful. I was shocked at the Panorama footage.

m. Sean Sayers I don't know this person.

n. ***Ryan Bromley*** I did not work closely with Ryan. I did not know him very well.

o. Daniel Small I don't know this person.

p. ***Yan Paschali*** I knew and worked with Yan. He had experience of working in secure settings previously. I think he found it difficult to transfer from working in a prison to immigration. I think the aggressive personality shown in the Panorama footage is potentially fair in terms of the way he acted, he was a strong character and firm in his opinions. I had not seen or heard anything before Panorama that gave me cause for concern.

q. Daniel Lake I don't know this person.

r. Babatunde Fagbo I don't know this person.

s. Shayne Munro / Munroe I don't know this person.

t. ***Nurse Jo Buss*** I knew Jo Buss very well. I worked with her as a staff nurse to senior nurse to clinical lead. She worked at Brook House / Tinsley House throughout my time at G4S. Jo was a very experienced nurse and had good values. I never thought Jo would say the things she said in the footage but I can imagine in the footage that her documentation would be basic and not very detailed. Some of her documentation was detailed and she had a huge amount of empathy with residents, sometimes she would spend too long with each resident. She had a lot of knowledge around Rule 35 and torture, she did a whole presentation to healthcare staff about it. I was sad and surprised to see she had said and done. She had worked in lots of settings. I never had any concerns about any of Jo's personal views or behaviours. I had a good personal relationship with Jo inside and out of work.

Suggestions for Improvements

Part of the Inquiry's remit is to identify learning and make recommendations that would help to prevent the recurrence of such events in the future.

154. Where not specifically covered above, set out your opinion of what could be changed or improved at Brook House in order to improve individual health, safety and welfare.

None to note additional to comments above

Any other Concerns

155. ***To the extent not covered by the above, please mention or explain any other matter which relates to the culture of G4S at Brook House, and the treatment of detained persons which you consider may be relevant to the Inquiry. In particular, the Inquiry would welcome any information that you have (this need not be limited to information that you have direct knowledge of) concerning whether in relation to any of the above topics there have been any significant changes such that the situation in Brook House is different now to the situation in 2017.***

I have nothing to add.

156. ***A list of names of individuals working at Brook House who you believe are knowledgeable about the matters that you have mentioned in your statement.***

Sandra Calver – Head of Healthcare, Chrissie Williams – Clinical Lead, Karen Churcher – Senior Mental Health Nurse.

157. ***Any further matters which you consider relevant to the Inquiry's work***

I have nothing to add.

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: **Signature** Dated: 05/11/2021

Name: MICHAEL WELLS