Emma Shurbrook

BROOK HOUSE INQUIRY

Sensitive/Irrelevant R

FIRST WITNESS STATEMENT OF JUNE WATTS

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 7 October 2021.

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

I, June Watts, of DPA, will say as follows:

Background

1. My full name is June Alice Watts and my date of birth is DPA

2. I qualified as a Registered General Nurse ("RGN") in 1971. I worked at Crawley Hospital until 1980 when I moved to work as a community nurse. I have also worked as a manager of a residential home, as a staff nurse and sister in Accident and Emergency and as a senior nursing officer on a cruise ship. In 2009, I started work as an RGN at Brook House / Tinsley House IRC employed by Saxonbrook. I still work at Brook House / Tinsley House IRC, however my employer has changed as the contract has been taken over by different companies over the years so I have worked for G4S and recently have moved over to Practice Plus Group.

3. I work nights from 19.00 to 07.30. I have mostly been based at Tinsley House IRC but when Tinsley House was closed, I transferred over to work at Brook House. I have been an RGN for the whole time I have worked at Tinsley / Brook House.

4. The healthcare contract at the Gatwick IRCs transferred over to Practice Plus Group on 1 September 2021, and my employment transferred over to them at that stage.

Application Process

5. I had worked for Saxonbrook Medical as a Community Sister before and I knew about Tinsley House from other staff. I also knew the nurse manager as I worked with him in A&E at Crawley hospital so I approached him to enquire about a job as an RGN at Tinsley House and arranged to visit him at the centre. I was able to spend a couple of hours with him at Tinsley House to see how it all worked and what the environment was like before I applied for a job there. The centre seemed very different to any of my previous roles and I thought it would be a new challenge, especially when Brook House opened.

6. I felt that the recruitment process prepared me for the role.

Culture

7. Brook House is a multi-culture environment including multi-cultured residents. Within healthcare, we have different cultures and skill mix. I have noticed that the culture has changed and it now seems to be quite cliquey at times and staff are more out for themselves. This could be because there is a lot of changeover of staff. Many staff are employed but don't stay for very long. I don't remember the culture being like this when I first started. I personally don't have any issues, I am a very experienced member of staff and many of the younger staff turn to me for support if they need it.

8. I was quite happy going to work and didn't encounter any issues. Everybody who works at the centre has a really hard time. Residents spit at us and verbally abuse us, and I was sexually assaulted around about Christmas 2017/8. I had never noticed any retaliation from healthcare or the officers. I don't think people really talked about Panorama. They talked more about the person who was working under cover and people were unhappy about that. I was very upset by what happened with Jo Buss. I couldn't believe what happened to her, she spent hours with residents at Tinsley House. I can't recall any obvious issues. I think we just supported each other. The relationship with the detention team carried on as normal for me. I didn't have any issues with them.

9. As far as I can recall I don't remember any issues regarding attitudes towards detainees in 2017. From what I saw, both officers and healthcare had a professional attitude to the residents.

10. As a nurse for 53 years, I didn't have any concerns about the care given to an individual with the scope of our practice and the numbers of staff available for each shift. In my opinion, more staff are needed to provide all of the care needed. I thought the mental health nurses, James Newlands and Daliah Dowd were outstanding nurses. I would often find them both after their shift finishing off their work. I didn't have any concerns about how residents with physical health, mental health, substance misuse issues or vulnerable people were cared for.

11. I am not aware of any concerns being raised about how detainees were treated by any member of staff.

Oversight

12.

i. ***The Independent Monitoring Board (IMB);*** The IMB is a statutory body established by the 1952 Prison Act to ensure residents are treated properly in the IRC. I didn't have any contact with the IMB at Brook House, but did have contact with them at Tinsley House. They would come in and do spot check or see detainees and see us and ask about any issues we had or any issues they had. Often detainees wouldn't speak to officers or us but they would speak to the IMB.

ii. ***The Gatwick Detainees Welfare Group (GDWG);*** The GDWG was set up in 1995. They are volunteers who visit the centre to support residents with their needs. They help them to make complaints where appropriate and can also help with some practical needs by finding second hand clothes and some phone cards. I didn't have any contact with them.

iii. ***Medical Justice***; they arrange for volunteers to visit residents in Brook House. They have doctors to visit and assess any resident who are claiming they have been tortured. I didn't have any contact with them.

iv. ***Bail for Immigration Detainees (BID).*** They are an independent charity and may challenge immigration issues. They want freedom for everyone. I didn't have any contact with them at Brook House.

v. ***And other external organisations***. I think mental health would be referred to a psychiatrist who came in to see them but I didn't have any contact with them.

General Training

13. I was employed to work at Brook House when it opened. Before the centre opened to detainees I underwent two weeks in house training provided by G4S staff. This included control and restraint, security and keys / radio talks and a tour of the centre. I also had a healthcare induction by the healthcare manager at the time. This covered all aspects of care / assessments / referrals / Control and restraint (both planned and unplanned) / emergency situations / deliberate self-harm / food and fluid refusal. Emergency equipment, health, and safety in Brook House was also covered. I also had ACDT training, which covered how to assess, plan, implement and complete the referral and who to inform when opening the ACDT. During this training, I was also introduced to SystemOne and how to complete entries on the system and the importance of complete and concise entries. As an RGN, I also had to keep my continuous professional development training up to date for my technical skills.

14. I felt the training I was given prepared me for the job at Brook House.

15. The essential training was the emergency training covering resuscitation, intermediate life support, C&R training, personal protection, ACDT, and my RGN CPD training.

16. I can't think of any improvements to suggest.

17. I can't think of any refresher training apart from intermediate life support, which I have to do annually in October/November time.

18. Online training was provided by G4S for certifications, there were about ten or eleven modules you had to do. They covered a lot of different areas including female mutilation. We also had to do training for carers families and children as we had families at Tinsley House. We also completed training on updating those at risk and safeguarding.

19. I had some C&R training on line. Also, when there is a planned C&R we go to the meeting beforehand with the officers. I think that a year or two ago we had a training day for C&R and

personal protection, but I can only remember having that one training session. I have not seen the Violence Reduction Strategy that I can recall.

19.1 I think it was just online training for Rule 35 and ACDT training. I don't recall going to any study days and I can't remember when it was. I haven't had any refresher training on Rule 35 or ACDT. I believe I have had some online training for suicide prevention and self-harm management.

Staff Induction

20. I did a two-week induction at Brook House prior to it opening for detainees. That induction was a multi-disciplinary induction provided by healthcare staff, discipline staff and admin staff and included security within the centre, for example key talks at Brook House.

21. I felt that the induction prepared me for my role.

22. I don't recall any problems with the induction.

I think the induction was good. I was lucky as I knew the manager at the time and I was able to spend an hour or two with him at Tinsley House. I haven't seen the actual training programmes for new staff but they usually come over to Tinsley House to work with me for 1 or 2 nights when they first start. I feel that their training could be improved by having a training manual for their role so they go through all the roles and what they do, then when they have worked through that they would be observed doing the role and when they are proficient they would be signed off.

Management of healthcare staff

23. In 2017, the healthcare team was a multi-disciplinary team of RGNs, RMNs and healthcare assistants (HCAs). Sandra Calver was the head of healthcare, I never met anybody above her. Michael and Jay were the practice managers then we had senior RGNs, RGNs, RMNs and HCAs. I can't remember whether we had pharmacist in 2017.

24. I didn't line manage anyone.

25. I didn't have any problems with Sandra. I never had a problem getting in touch with her. I would call her if I needed her and we have to get in touch if we are sending someone to hospital or if there was an issue we would just telephone her. I didn't really have any contact with any other managers as I worked nights.

26. Sandra Calver was my line manager and is still my line manager now. I didn't have any issues with her. I had appraisals yearly I believe, but the appraisals were not always done by Sandra. Jo Buss was my mentor and she did my CPD and clinical supervision.

27. In 2017, I felt supported by the healthcare team. I think it has changed slightly now, although I have to say I think it has changed for other members of staff more than me.

28. Each person had someone who would do his or her clinical supervision as far as I know.

29. Jo Buss did my clinical supervision. From memory I think this was done monthly face to face, we would go through it and sign it.

30. I didn't have any problems with my clinical supervision.

31. I think it works well and have no changes to suggest.

Disciplinary and grievance processes

32. I have never been involved in any disciplinary or grievance investigations.

Staffing

33. During the Relevant Period, I only worked nine nights at Brook House as I usually work at Tinsley House on night duty only. On the nights I worked there were two members of healthcare staff on duty including myself. It was normal to have two members of staff on duty at night at Brook House. There would always be one trained member of staff and possibly one HCA but at times there would be two trained nurses on duty.

34. I personally feel that in 2017 when we were really busy it would be ideal to have more staff on duty at night. We could have up to 75 people coming to collect their medication, more residents arriving so requiring a health screening and could then have a medical response (emergency) call to deal with. At the time we were completely aware of what needed to be done and we coped but I don't think looking back that we had the time to give 100%.

35. To my knowledge agency staff have always been used at times if staffing levels were low with the permanent staff. I can't remember the ratio of agency / permanent staff.

36. I believe some of the agency staff also worked at other IRCs so were used to working in detention centres and some of the staff have worked in prisons.

37. I cannot comment on whether agency staff were familiar with the systems and procedures at Brook House. I don't know about any induction or training for agency staff so cannot comment on that.

38. I don't think the number of agency staff affected the provision of healthcare at night. I cannot comment about during the day, as I did not work then. The number of staff, not the fact that agency staff were used, affected the provision of healthcare at night. It is just as busy at night as we have more residents coming in at night as the transport is used during the day for taking prisoners to prison/court rather than bringing detainees in so they are brought at night. The detainees could have been at the airport for 12 hours before they are brought to us so they are not always in good humour when they arrive. We also have problems with detainees who call us because they cannot sleep at night and get angry because we cannot prescribe them medication.

39. I think the impact goes back to pressure of work and workload levels, in particular for the mental health service. Their time might be limited when residents need more time.

40. The impact of shortages of permanent healthcare staff can lead to tiredness and low morale, I would say this mostly affected morale. It can be very pressured on the night shift for example when we are in the pharmacy and have 75 medications to give out, with some patients having 3 or 4 lots each and we are then called to an emergency. It can be difficult to balance everything.

41. In 2017, I think the staff levels for officers were better than they are now.

42. I cannot comment on the activities team as I work on the night shift so don't really have any contact with the activities team.

43. Relationship between Healthcare and Detention Staff

a. The officers are really good in my opinion. I personally have had no issues with them. It's a two way relationship, and that's what makes it good. At Tinsley House I've been there since 2009 so I know all the staff and that makes a difference. At Brook House I don't really know the officers but I've still had no issues with them they've always been helpful, pleasant and you can have a conversation with them or share a laugh with them and that's a release sometimes.

b. Certain staff are C&R trained and it works well. When there is a planned use of force it's done really well and even if it's not planned they do a good job even though they are having to make decisions in the heat of the moment. When it is a planned use of force there are more officers, each know what their job is before go into the situation and there has been a briefing first. If we have any concerns for example a patient was distressed or if a patient's breathing was compromised we can tell them to stop, I've never had to do that.

c. From what I can remember there were no problems, communication was good. If an officer was concerned about a resident they would bring that to our attention. We are restricted due to medical in confidence regarding what we can share but if there is something officers need to know about they have a confidentiality responsibility too.

d. I don't have any specific examples but I generally most officers do a really good job. They have to tolerate verbal abuse, and being spat but there is nothing they can do about it. Some are less tolerant than others but all officers have been professional in my experience.

44. I found the detention staff to be very accommodating, helpful and supportive and in certain situations, I have felt protected by the detention staff. I cannot remember any situation where an officer did not assist where needed. They have always been polite and respectful in my presence.

45. I do not recall any problems with healthcare from officers and do not have any improvements to suggest.

Relationship with Home Office

46. I do not have any comments regarding the Home Office as I only work nights, so I only pass the Home Office staff coming or going out of the centre. I didn't experience any problems with the Home Office as I didn't have any contact with them.

Reception / Healthcare Screening / Induction

47. The timing of when the healthcare screening was done after the detainee arrived at the centre depended on how many detainees arrived at one time. At Brook House they were seen very quickly, we are informed when transport arrives, and they are usually seen within 30 minutes to 1 hour at the most but this would depend on how many people came in at once. At nights with only two members of staff on duty, if six or seven people came in at once, which was normal in 2017, they wouldn't be seen as quickly. With 400 detainees to two nurses, if one nurse was dealing with admissions and there was an emergency call, we would have to stop admissions and prioritise the emergency.

48. Healthcare screening is done during the day and also at night in the two rooms behind reception. The screening is done by an RGN, or a healthcare assistant. We used language line if an interpreter was needed. We had booklets that were given to detainees that were available in different languages. Those booklets contained information about how to contact healthcare, who we were, where we were, the fact they could contact us 24/7, and how to get to us by the officers if it was lockdown.

49. Individuals can request their medical notes but on discharge they are given a copy of their medical records. We also receive medical records from a previous Immigration Removal Centre ("IRC") or paramedics if they have been seen before they arrived at Brook House. On occasions we also received A&E notes. If someone arrived without any records we would get details of their GP in the community and obtain their consent to access their medical records. I would then pass that information on to the day shift staff and they would apply for the records.

50. If detainees arrive with medication, provided it is in date and in the original packaging with their name on the box with clear instructions of use and if the individual has signed an in possession form, then they can be given the medication. If any of these points are not covered then they will be given an appointment to see the doctor as soon as possible for a medication review. If someone could not have medication in their possession it is kept in the pharmacy and given out at medication times. Some medication cannot be held as in possession medication for example paracetamol as this can be used to overdose. Psychiatric medication and sleeping tablets are not allowed for in possession.

51. If an individual arrived on medication but without it in their possession, we could check with the on call doctor for advice and if they need medication we have emergency medication kept in stock. This is given when the doctor has given verbal consent for the medication to be given and is entered in the tasks for the doctor to sign when they next comes in. If we do not have the medication in stock and it must be given to the detainee, then we can send the detainee to

hospital but this does not happen very often. The detainee would be seen by the GP the following day and they would do a medication review. The prescription is then sent to Boots at Gatwick and sent over within 48 hours.

52. The healthcare screening covers physical and mental health issues, and substance misuse or any other vulnerabilities the detainee may have. Any diagnosed physical or mental health condition is treated as required by the nurse doing the health screening and an appointment is made with the doctor as soon as possible. For mental health conditions, if the person is stable then a referral is made to the RMN. If there were any concerns for mental health issues or substance misuse or any other reason, an ACDT would be opened and the centre manager informed. We would also make an appointment with the doctor for the following day anyway. The doctor on call can be contacted with any issues.

53. Someone with a substance misuse issue would be placed on E wing depending on what substances they are taking and how often and how long ago they last used. The doctor will be contacted and depending on the addiction they may be prescribed medication. The individual will be monitored by healthcare as they withdraw and the doctor will visit daily while they are detoxing. In 2017 we did not admit individuals who were misusing substances as we do now.

54. If we were concerned about anyone and thought there was a risk of self-harm or suicide they would be placed on an ACDT, and put in a room by themselves on constant watch if deemed necessary. They will be seen by the doctor as soon as possible and referred to the RMNs. All individuals are seen by the healthcare on arrival to the centre and have an appointment with the doctor. They are informed of availability of healthcare and how to access healthcare.

55. Individuals are put onto one of the wings, I think it was B wing, for the first few nights in the centre. They would also be told when they were screened by us how to contact healthcare, they would tell the officers and they would call us. It didn't happen often but it did happen.

56. After the first night in the centre detainees can access healthcare at clinics in the day time. But at night when I'm working they would call the officers and they would contact us. This was the standard process and it didn't vary.

Healthcare Facilities and Equipment

57. Brook House healthcare has two rooms next to reception where all new arrivals are seen and basic observations are taken and recorded at the time of assessment. This gives nurses the option to assess if there are any medical issues, for example high blood pressure, diabetes. The main medical department has a doctors consulting room, a pharmacy and nurses room with equipment for simple investigations for things like chest pain, diabetes and asthma. If the doctor wants further investigations we can do blood tests, ECGs and other simple tests. The mental health team are down the corridor from healthcare and they have their own room with a couch and the equipment they need, for example a telephone and computer.

58. We had what we needed to do our job, and if it was necessary we will send them out to hospital. We can do an ECG, blood sugar, all baseline observations, consciousness and things like that. If more was needed we would call an ambulance and send them to hospital.

59. We had the equipment we needed to deal with simple investigations and tests, as I have described above. In emergencies, we had the emergency equipment with a defibrillator, oxygen and diagnostic equipment and emergency medication.

60. All medical equipment is kept in healthcare. This caused problems when a medical response is called at night, there are only two medical staff on duty. If one is with admissions and if for example the other is on the wings already, it is the responsibility of healthcare to go and collect the equipment and take it to the emergency. This wastes valuable time going to collect the equipment which is heavy and cumbersome with two bags and a cylinder of oxygen. This could be improved if an officer could go and collect the equipment so we could go straight to the emergency. We were also delayed getting to the wings as we couldn't risk getting stuck in a lift so have to go up the stairs carrying all the three bags and have to unlock every door and lock it again. This has always been a problem at night. If a defibrillator was put on each wing that would save us from having to carrying the defibrillator.

Access to Healthcare

61. Detainees could always access healthcare at any time. There was a GP on site every day and a pharmacist to prescribe medication. I am not sure whether we had a pharmacist during the Relevant Period. There was also an optician and dentist that visited Brook House when required. I think the dentist visited once a week but I cannot be sure. They were all external. This was all done during the day when I was not on shift, so I did not have much involvement in organising detainees' appointments.

62. Detainees could request to see healthcare at any time if they were suffering with poor mental health and they would be referred on to the RMNs. A psychiatrist attended Brook House to see detainees that had been referred but as I work night shifts, I had no involvement in this.

63. When I worked in Brook House whilst Tinsley House was closed for refurbishment, I was informed that if a detainee wanted to see a doctor or nurse they had to obtain a form from the wing officers to complete requesting an appointment. The wing officers help the detainees to fill in the forms if required. These forms are then collected and taken to healthcare and appointments are arranged. Previously the officers would call healthcare and ask us to attend the detainee's room to see them and we would always attend quickly, depending on what other work we were doing at that moment. I can't remember when this changed. For detainees to see a RMN or GP, they would have to be assessed and referred by a RGN. RMNs or the GP could refer a detainee to the psychiatrist.

64. I don't think there were any reoccurring problems with detainees accessing healthcare. Occasionally if there were only two members of healthcare staff on shift and we were attending

an emergency call out and a detainee was unwell, we would not be able to see them as quickly as we would like to.

65. Emergency call outs caused delays in providing healthcare to other detainees, as emergencies always had to be prioritised.

66. I think more healthcare staff were needed on night shifts at Brook House. Three members of staff would have been ideal, preferably two trained nurses and one healthcare assistant.

Detained Persons

67. Immediately before and during the Relevant Period, a lot of detainees were suffering with mental health conditions. Detainees would come to healthcare and tell us that they had not been sleeping well and were feeling suicidal. A lot of detainees were self-harming. Immediately after the Relevant Period, I still found that a lot of detainees were suffering with low mood and sleep deprivation. In 2017, the detainees were also of a higher age group, so a lot of them were suffering with heart conditions, diabetes and high blood pressure.

68. It was difficult for healthcare staff to ensure that those detainees who needed to be admitted to hospital actually went. There was always long wait times. We could send them as an emergency and call 999 but this also sometimes took a while. The lack of healthcare staff was the main challenge for us in managing the detainees' health conditions. In order to provide the best level of care, more staff members were definitely needed.

Interpreters

69. We used interpreters a lot at Brook House. Language Line was often used and we could access interpreters over the telephone. There were also multi-lingual officers who would offer to help if the detainee consented. Having someone else in the room who could speak their language was comforting to some detainees.

70. Interpreters were usually always available when needed. There were occasional difficulties with some of the less common languages such as Arabic, as there would be less interpreters available so wait times would be longer.

71. I don't think there were any problems with obtaining interpreters for detainees in Brook House.

72. When healthcare were assessing a detainee who could not speak English and we were struggling to obtain an interpreter right away, it would be difficult to identify any underlying health conditions that were not obvious. For example, if a detainee was suffering with a mental health condition and we were still awaiting an interpreter or full translation, this would not be identified and treated as quickly as we would like.

Supported Living Plan ("SLP")

73. The purpose of a SLP was to provide support to detainees who needed more assistance to maintain daily living.

74. If a detainee was suffering with any disabilities for example, if they had an artificial limb or were blind then a SLP would be opened. SLPs could also be opened for any temporary issues such as if a detainee was on crutches and needed extra support moving around the centre.

75. Healthcare staff completed the SLPs and assessed the level of support that detainee required. Healthcare staff ensured that the right measures were put in place to ensure the detainee could live in Brook House safely. We would conduct reviews as necessary and close the SLP when the detainee no longer required assistance.

Complaints

76. If detainees wanted to make a complaint regarding healthcare, I think they could contact immigration, IMB or their solicitor. They could also come to healthcare and make a verbal complaint and we could try to sort out the issue there and then.

77. I was not involved in any complaints or investigation processes.

E Wing

78. Detainees were placed on E-Wing for a number of reasons. If healthcare staff were worried about a detainee who was suffering with a health condition but it did not warrant hospitalisation, the detainee could be placed on E-Wing for closer observation. If a detainee was withdrawing from drugs or if a detainee was a risk to other detainees they would be placed on E-Wing. E-Wing also had single cell rooms for any detainees believed to have an infectious disease.

79. A detainee would be placed on E-Wing for their wellbeing and safety. It was a much smaller wing, so staff would be able to keep a closer eye on the detainees. It was a more supportive and more protective environment.

80. Detainees on E-Wing would be seen and assessed daily by healthcare staff and the GP. Medication was also taken to the detainees, as opposed to them coming to the pharmacy to collect it.

81. There was also a Care and Separation Unit ("*CSU*") in Brook House. For a detainee to be placed there, they would have to have been very disruptive or violent. Detainees who had attacked other detainees or members of staff were often placed there. In my experience, I did not see a lot of detainees in CSU. It was only ever used as a last resort. Occasionally if a detainee was due to be deported and was refusing, they would be placed in CSU for a couple of hours before being removed from the centre.

82. If the detainees on CSU were not suffering with any medical issues then healthcare would not attend. Officers would advise healthcare staff not to go into the room in CSU unless it was absolutely necessary, as most detainees placed there were violent. We would only really attend in an emergency situation, as opposed to conducting regular checks.

Medication

83. If a detainee was prescribed medication to remain in their possession, they would have to undergo an assessment by healthcare and the GP to ensure they are fit to have and keep the medication. The detainee must also sign an in possession form to agree not to share the medication with anyone else and keep it safe. There are certain types of medication that cannot be kept in possession such as sleeping tablets or paracetamol due to risk of overdose.

84. If a detainee was prescribed medication that they could not keep in their possession, they would need to attend the pharmacy at the set times to collect it. Healthcare administered medication three times a day.

85. I don't think there were many problems with managing the detainees' medication. Occasionally if there was an emergency call out during medication time, we would have to close the pharmacy and attend the emergency response. This would cause delays in detainees obtaining their medication.

86. I don't think there were any improvements to be made in relation to the management of detainee's mediation.

Drug / alcohol misuse

87. All new detainees undergo healthcare screening upon their arrival into Brook House. Healthcare staff were trained to look for signs of substance or alcohol misuse such as tremors, slurred speech and constricted pupils. Detainees would also sometimes inform you during screening that they were suffering with substance misuse issues.

88. Detainees suffering with substance misuse issues would be seen by the GP for further assessment. If they had severe withdrawal symptoms then they could be placed on E-Wing where they could receive higher levels of support. If it was felt that we could not provide adequate care, the detainee would be transferred to hospital or to another centre.

89. I don't think there were any substance misuse services available in Brook House during the Relevant Period. I only work night shifts, so I do not have a lot of involvement with detainees suffering from substance misuse issues once I have assessed them.

90. I cannot comment on whether the services and treatment available for individuals with substance misuse issues was adequate, as I was not involved enough.

91. I cannot comment on any improvements that could have been made to the services available for detainees suffering with substance misuse issues.

92. During the Relevant Period, there was a huge spice outbreak in the centre. Healthcare staff used to attend a lot of emergency calls during the night, as a result of spice. Spice caused detainees to have many different reactions. Most detainees recovered quickly. We would always keep a close eye on them once they had recovered from the effects.

Healthcare staff would attend emergency call outs when detainees were having a bad reaction from drugs. We would give immediate care and follow up with detainees after they had recovered.

93. I don't remember alcohol being in Brook House during the Relevant Period, it was mostly spice.

94. During the night shifts, there were only ever two members of healthcare staff on duty. It was usually one trained nurse and one healthcare assistant. This was stressful, as the trained member of staff would always have to oversee the healthcare assistant. We definitely needed more members of staff on shift to balance the workload and ensure detainees always received the appropriate level of care. There was also only one set of emergency equipment in the centre. If two emergency responses happened at the same time, this would not have been enough equipment to treat both detainees.

95. I did not have any concerns about the appropriateness of detention staff's management of individuals who were intoxicated.

96. If I had any concerns, I would have raised them with my line manager immediately.

Mental Health

97. All detainees are health screened on arrival and if any mental health issues are identified then the detainee is referred on to the mental health team. RMNs could refer the detainees to a psychiatrist if necessary and the psychiatrist would attend Brook House.

98. I did not have any concerns about healthcare staff's management of detainees suffering with mental health conditions. We had a really good mental health team in Brook House.

99. I did not have any concerns about the appropriateness of detention staff's management of detainees suffering with mental health conditions.

100. As I did not have any concerns, I never felt the need to raise anything with my manager or any senior members of staff.

Rule 35 reports

101. I was not involved in the writing of Rule 35 reports. All Rule 35 reports were completed by the GP.

102. The purpose of a Rule 35 report was to identify any detainees that had been victims of either mental or physical torture. Rule 35 reports were to prevent the detainee from being sent back to their place of torture.

103. Detainees would come to healthcare and ask for a Rule 35 report to be carried out. We would refer the detainee to the GP and arrange an appointment for them to undergo a Rule 35 assessment. This would be recorded by the GP.

104. I have never been involved in deciding whether a detainee is suitable for ongoing detention. This is decided by the GP, mental health team, immigration and the detainee's solicitor.

105. Healthcare conduct an initial assessment of the detainee and we then refer them on to be seen by the GP for a full Rule 35 report. The GP asks the detainee a series of questions and completes a Rule 35 form. The GP will also examine the detainee's body for any scarring and mark them on a body map.

106. All healthcare staff were responsible for ensuring compliance with clinical standards and the implementation of Rules 33-35 of the Detention Centre Rules safeguards.

107. During the Relevant Period, there were only two members of healthcare staff working on a night shift and a the majority of detainees were brought in at night. A new patient assessment could take up to an hour if the detainee advised that they required a Rule 35 appointment. We were under a lot of pressure to see detainees within a certain time, so due to the low levels of staff it would be difficult to spend the adequate amount of time assessing these detainees.

108. I did not have any concerns about the process of assessment and writing of Rule 35 reports and therefore did not raise any.

109. During the Relevant Period, there was often long wait lists to see the GP for a Rule 35 report. Having more than one GP on site would have helped reduce the long wait times.

ACDT and self-harm risk management

110. I opened a number of ACDT documents for detainees who required them and would check in on detainees daily and conduct assessments.

111. Detainees who were at risk of self-harm or suicide were identified by many different members of staff in Brook House. Officers would refer detainees to us who they were concerned about, immigration and the GP would also identify detainees who needed to be placed on an ACDT. Detainees would also sometimes self-declare and attend healthcare advising that they were having thoughts of self-harm or suicide.

112. Healthcare staff conducted an initial assessment of the detainee at risk of self-harm or suicide and if necessary, opened an ACDT document.

113. Healthcare staff would conduct check-ins with the detainee as and when necessary and make notes within the detainee's ACDT booklet. The detainee's healthcare records would also be updated constantly.

114. I did not have any concerns about the appropriateness of healthcare staff's management of individuals who were at risk of self-harm or suicide.

115. I did not have any concerns about the appropriateness of detention staff's management of individuals who were at risk of self-harm or suicide.

116. I never raised any concerns with any members of staff, as I did not have any.

ACDT

117. ACDT documents are opened when a member of staff is concerned for a detainee's safety and mental wellbeing.

118. An ACDT document would be opened if a detainee was expressing thoughts of self-harm or suicide or depression. If staff members had noticed a detainee was acting in a certain way that concerned them, an ACDT document could be opened.

119. There was no threshold for opening an ACDT document. Anything that concerned a member of staff in relation to a detainee's mental health and well-being could justify an ACDT document being opened.

120. Once an ACDT document had been opened, healthcare and an Oscar manager had to be informed. The staff member who opened the ACDT document would need to fill the booklet in explaining the detainee's condition.

121. The management of a detainee on an ACDT document depended on the level of risk the detainee posed. If a detainee was deemed high risk and needed to be on constant watch then they would be placed on E-Wing and it would be arranged for an officer to see them every hour or two hours. If the officer had any concerns, they would be reported to healthcare and we would attend.

122. Detainees on ACDT documents would be reviewed by healthcare. How often the reviews took place depended on the severity of the detainee's condition. Review meetings would be attended by healthcare, an Oscar manager and the detainee.

123. ACDTs would be closed when all members of staff were satisfied that the detainee no longer posed a risk to himself. The detainee would have to be in agreement before the ACDT was closed.

124. ACDTs were never challenged. If someone deemed it necessary, an ACDT would be opened.

125. Healthcare staff could ask to see the detainee on an ACDT document as often as we liked. We would conduct assessments and ask them how they are feeling and ensure that their needs were being met. All assessments would be documented in the detainee's ACDT booklet.

126. I did not experience any problems with the management of detainees on ACDT documents.

127. I do not think any improvements could have been made in relation to the process of managing individuals on ACDT documents.

128. Multi-Disciplinary Team meetings were often held and attended by healthcare. I did not attend these meetings personally but I understand that their purpose was to discuss detainees with particularly complex health issues and decide on the best ways to support them going forward.

129. I never attended any Safer Community Meetings and Adults at Risk meetings. I understand that they were only attended by detention staff. I am not sure if any other members of healthcare staff attended. I am not familiar with what would have been discussed at these meetings.

130. I don't know if there were any mechanisms in place to offer support or counselling to individuals at Brook House who had witnessed a violent or distressing event. The mental health team were always there to provide support.

Food and Fluid Refusal

131. Officers always kept a record of meal times and whether each detainee had eaten or not. If a detainee had missed all of their meals for the day then healthcare would be informed and we would conduct an assessment of the detainee. We would talk to them and ask them why they were refusing to eat and try to understand their issues.

132. Healthcare would see the detainee on a daily basis and conduct check-ins to monitor the detainee's condition.

133. Specific food and fluid forms needed to be completed by healthcare every time they conducted an assessment on a detainee.

134. In my experience of detainees refusing food or fluids, most refused because they thought several things would happen for their benefit. For example, they thought they would be released from Brook House. It was very distressing to see detainees refuse to eat and become weaker and weaker.

135. I did not have any concerns about the appropriateness of the management of individuals who refused food or fluids.

Use of Force

136. If use of force is being planned in relation to a detainee, healthcare attend the pre-meeting with the officers. Healthcare were there to maintain the detainee's safety. We would ensure that the officers were alerted to any underlying health conditions the detainee had beforehand and we would ensure that the detainee's safety was not compromised in any way.

137. Use of force is permitted in circumstances where it is necessary in order to protect the detainee or others. If a detainee was trying to harm themselves or if they were violent and destroying property, use of force would be used.

138. All uses of force are documented in System 1. There are specific use of force forms that need to be completed.

139. Healthcare always follow up with a detainee following a use of force to check whether any injuries have been sustained. This is usually done between 1-2 hours after the use of force took place. Healthcare would then relay any concerns to the medic.

140. I have witnessed and been involved in use of force incidents a few times on night duty. Our role was always to ensure the detainee was safe. If I had any concerns for example, if I thought the detainee could not breathe properly then I would tell the officers to release the detainee and they always would. Use of force forms would always be completed after the incident.

141. I never had any concerns about the appropriateness of the use of force on an individual. It was always well planned. The officers always did their best to avoid any injuries being sustained to the detainee.

The Panorama Programme

142. I never worked with Callum Tulley and I did not know who he was until after the Panorama programme.

143. I do not appear in the Panorama programme.

144. Following the Panorama programme, staff morale throughout Brook House was very low. It was awful. The programme was very one-sided. It did not show how the detainees behaved towards staff. Staff were often spat at and verbally abused by detainees. We were all very angry and upset.

145. I am not aware of any detainees seeing or being notified of the Panorama programme.

146. I cannot remember being involved in any age dispute cases in relation to underage detainees.

147. I can't remember if there were any changes implemented at Brook House following the Panorama programme.

Specific Individuals

148. I knew Nathan Ring from around Brook House. He was helpful and nice to work with. I never witnessed any concerning behaviour.

149. I do not know Steve Webb.

150. I knew Chris Donnelly. I saw him quite often and he was always very pleasant. I never heard him raise his voice or be rude to anybody. He was always very professional.

151. I do not know Kalvin Sanders.

152. I do not know Derek Murphy

153. I do not know John Connolly.

154. I do not know Dave Webb.

155. I do not know Clayton Fraser.

156. I do not know Charles Frances.

157. I do not know Aaron Stokes.

158. I do not know Mark Earl.

159. I do not know Slim Bassoud.

160. I do not know Sean Sayers.

161. I do not know Ryan Bromley.

162. I do not know Daniel Small.

163. I do not know Yan Pacshali.

164. I do not know Daniel Lake.

165. I do not know Babatunde Fagbo.

166. I do not know Shayne Munro.

167. I worked with Nurse Jo Buss a lot. She was a very experienced nurse. I definitely did not have any concerns about her. She was an excellent nurse and she would spend so much time with each detainee. I would often take over from her to do my night shift. She would always stay beyond her required hours. She was very dedicated to her job.

Suggestions for Improvements

168. I do not have any further suggestions for improvements in relation to Brook House.

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: 08-11-2021

Name: June Alice WATTS