BROOK HOUSE INQUIRY

FIRST WITNESS STATEMENT OF EMILY PARR

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 1 October 2021.

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

I, Emily Parr, of DPA will say as follows:

Background

1. My full name is Emily Jaine Parr and my date of birth is DPA

2. I have a diploma in Higher Education and I graduated in 2013 from Kingston University. I trained as a learning disability nurse and worked in a special educational needs school and then a dementia home. I began working for G4S in August 2014 until April 2021 at Brook House, Tinsley House and Cedars as a Registered Nurse. I was absent from work for long periods during my time at Brook House, particularly in 2017, as I had to undergo brain surgery as a result of suffering from severe epilepsy. My health condition has affected my memory and it can take me a little longer than usual to process things and my memory from 2017 is quite patchy. I now work for Change Grow Live as a Health and Wellbeing Nurse. I began working here on 12 April 2021.

3. I worked for G4S from August 2014 until April 2021 at Brook House, Tinsley House and Cedars as a Registered Nurse. I would do the same work as the Registered General Nurses ("RGN"). If there were any residents who had a diagnosis of a learning disability or staff had concerns they may potentially have a learning disability, they would ask me to go and screen them.

4. I had been at Brook House for a number of years and in early 2021 I was considering whether it was time for a new challenge. I had attended an interview for the job I am now doing and unfortunately a member of staff at G4S disclosed that I had attended an interview for another health service, which led to an uncomfortable working environment at G4S. I loved my job at G4S, but I felt like a needed a new challenge.

Application Process

5. During my training as a nurse, I had worked in secure environments and I found it interesting. Brook House was closer to home than where I was working at the time and at that point, it was a reasonable rate of pay. An agency I was listed with at the time sent me the advert for G4S and they told me that G4S were looking for Registered Mental Health Nurses ("RMN"). As I wasn't an RMN, I wasn't confident that I would get the job but I attended an interview and was successful.

6. During my interview, I was taken in to the centre and was walked around afterwards. I was shown around healthcare and briefly around the wings. As there was such a long period of time between the interview process and actually starting the job, it is easy to forget things. The clearance process takes a while therefore a few refresher sessions closer to the start date would have been helpful. I don't think the recruitment process fully prepared me for the role.

Culture

7. Brook House could feel quite oppressive. You would be there for 12 hours a day and there was no daylight, it was quite a low mood environment. In healthcare it was very supportive at the beginning however I felt that as some staff members left the team dynamic changed, and so the culture was slightly different. Management changed and sometimes you would have to remind them that you needed help in order to get the support you required. In my opinion, it became quite a cliquey environment. There were some operational staff who were unable to support your requirements, other staff were quite open and ready to help you if needed.

8. The Panorama documentary aired around the time I had just returned to work from two lots of brain surgery. I was on a gradual return to work and I was not doing full shifts. Morale was low throughout the centre and not just in the healthcare team, it was widespread. There were a lot of first responses (emergency responses where operational staff and a member of staff from healthcare attend) at the time, as there was a Spice outbreak in the centre. This caused healthcare to be very busy. I have always found healthcare morale to be low and it has never improved.

9. Healthcare staff only went out on to wings when we were required for medical responses or if we had to go and do admissions. The mental health team would undertake the ACDT reviews. In regards to healthcare, the detainees were our patients so, after Panorama we discussed it and how we could move forward and what we could do in healthcare differently. Our interactions were always caring. I would say that the operational staff were professional when removing residents that we had raised the alarm over.

10. I am quite comfortable with raising concerns if I consider this is necessary. I know the process to raise concerns and I have raised concerns before. I raised concerns during a control and restraint ("C&R") when a detainee was transferred and was under Mitie's. Mitie used unreasonable verbal and physical force and I raised this with my Head of Healthcare who advised me to write a written statement and this was passed on to the Home office. I can't remember the date, I don't know if this was pre Panorama. I think something was put in place following this, as it was then said that Mitie could not put their hands on detainees. I also put a concern in regarding training of the officers and their C&R training, as an officer injured their arm in C&R training and I had to send him to hospital.

11. We sometimes had issues communicating with the hospitals in relation to the management of individuals with physical health conditions. The hospitals would assume that we had a bed because we were a healthcare facility and we didn't. Occasionally they would discharge people with health issues that were not suitable for us to manage.

12. Those with mental health concerns would see the mental health team but the mental health team could only do so much. If someone was waiting to be sectioned because they were with us they were not seen as a priority. The staff on the wing weren't trained in this area and because we are not there all of the time, I felt the detainees were not getting the support they needed. That didn't happen often but it did happen and I e-mailed voicing concerns. I can't remember when this was, it might have been 2017/2018.

13. I didn't have any concerns regarding individuals who could be considered vulnerable over and above the matters I have detailed elsewhere in this section.

14. I did have concerns about the management of individuals with substance misuse issues. I can't remember the exact date or year. My concern was that we had two rooms for healthcare for those people who were withdrawing from substances, these were full at the time and we were informed that there was someone else coming in withdrawing from substances. We only have two rooms for these detainees as they need assistance during the night. I was concerned that we didn't have enough resource to take someone else on. I raised this concern and used the Speak Out line.

15. Any safeguarding concerns regarding the protection of individuals regarding the type of abuse seen on the Panorama programme would be raised with Sandra Calver the Head of Healthcare.

16. There was a client a while back that we had safeguarding concerns about but I can't remember his name. Any safeguarding concerns, would be raised with Sandra Calver the Head of Healthcare. I cannot remember any specific incidents and I am not aware of the reaction to it from detention staff or healthcare staff management.

Oversight

17. ***The Independent Monitoring Board (IMB)***; the IMB independently monitor processes within the centre to make sure they are of an appropriate standard. They occasionally came to me and asked about clients. The IMB would normally come with quite a long list and it was easier for them to have one point of contact, which was often Sandra.
18. ***The Gatwick Detainees Welfare Group (GDWG)***; they are a charity, I didn't have much involvement with them at all. They looked after the welfare of detainees.
19. ***Medical Justice;*** We did have involvement with them as they would come in and provide a doctor or a health representative for the client so that they could have a second opinion almost. They complete an assessment and this would be reviewed and sent to Healthcare and that's where we would have our involvement. We would never see them face to face really.
20. ***Bail for Immigration Detainees (BID)***. I didn't have much involvement with BID and I'm not familiar with how they work.
21. ***And other external organisations.*** I don't remember any other external organisations.

General Training

22. I can't remember the exact training I attended when I first started at Brook House. As a RGN I have to do continuous professional development, I have always kept up to date my CPD. I remember that I had personal protection training and I observed other nurses during the course of their days to understand how the days went. I also had training on Rule 35 and adults at risk; a key talk and radio talk. I also had training in regards to long term conditions, vaccinations, safeguarding. There was online training such as infection control, health and safety, fire safety. These were through AA, an external training provider. Some of the training was provided by G4S including information governance, security training. There were other training courses on there that were not mandatory that you could choose to do. We were then asked to our RGCP (Royal College of General Practitioners) online once we started getting detainees who suffered with substance misuse. We also completed Basic Life Support and Intermediate Life Support training.
23. I would have liked some further training on ACDTs. That would have been helpful to have when I first started, even though I know they do it now. There was also training on self-harm

etc. which would have been helpful, I think they also do this now but not at the time I started. De-escalation tactics would have been helpful to prepare me for my role in Brook House.

24. ECG interpretation training was essential to fulfil my role in Brook House as there were times you would have cardiac patients. Life support training was also essential.

25. Novel Psychoactive Substances training would have been helpful, I have had this in my current role and it has been very beneficial. Some sort of support with leadership and management training for when I was promoted to a Senior Nurse in 2018 would have been really helpful.

26. There was a lot of refresher training online that we had to do. I do not have the details of the courses I attended or completed online. I think personal protection and ACDT training should have been yearly.

27. There was a mixture of training providers, it could be G4S or external people. I do not have the details of which training was provided or the dates of the training as this was a number of years ago and I no longer work for G4S.

28. C&R training was very minimal. Originally we went with a more experienced member of staff to the C&Rs and observed and then we were given a chance to ask questions. There was always a debrief meeting after these events with the clinical lead or Head of Healthcare. It was explained to us how to complete the relevant forms and the importance of doing so correctly. From memory, there was not a specific course that we had to attend it was just observations.

29. There was an online suicidal thoughts and self-harm course that we had to complete around 21 December 2020. The Home Office provided training on adults at risk and Rule 35, this was a one day course. I think this was provided just after the Relevant Period but I cannot remember.

Staff Induction

30. The first induction week in Brook House was from 9am until 5pm. We read through policies and procedures and became familiar with the new systems. The second week consisted of shift work and we would shadow the RGNs and RMNs. I shadowed Chrissie, Lyn and Louise during my time. We were taken out onto the wing and talked through the procedures and shift patterns.

31. I don't think the staff induction process prepared me well for my role at Brook House. I really struggled. I had been in the field for 6-7 months when I started in Brook House, so I was still rather new. The induction process was not enough to prepare you for what you were going to experience in the centre. There was a lot of responsibility early on.

32. There was no official staff induction process. It is really difficult to lead an induction and support new members of staff whilst still trying to complete your role. I think an induction needs to be the sole responsibility of designated members of staff.

33. There should be particular members of staff who take charge of the induction processes.

Management of healthcare staff

34. In 2017, healthcare was structured as follows: Clinical staff Head of Healthcare, Clinical Lead, senior nurses, RGNs, healthcare assistants, senior mental health nurse and the mental health nurses. Business Staff: Practice Manager, admin staff. Some staff would be split between Cedars, Tinsley House and Brook House

35. I did not line manage anyone when I was a RGN. I may have done supervision with staff members but I was not their line manager, they reported in to Sandra as Head of Healthcare.

36. The practice manager, Michael Wells, was very approachable. I didn't always find the Head of Healthcare as approachable if she was busy and she was under pressure or in a meeting.

37. Chrissie Williams was the clinical lead and I found her to be approachable and very helpful. She was always happy to help and she really worked hard. Sandra was my line manager. I would say my relationship with Sandra was neutral. I didn't have any issues with Sandra and I don't think she had any issues with me. I can't remember much but I think sometimes Sandra was split between sites and you would have to call her on the telephone but usually she would be easy to find. Chrissie and Michael Wells were easily accessible. It was easy to find at least one manager.

38. My experience of working with other healthcare staff varied over the course of the years and varied depending on members of staff. It depended on who was on duty. It was quite full on in healthcare, you had a lot to do. There were times where you found that you were having to pull it all together almost because other people were perhaps not pulling their weight. When everyone was working together, it worked well.

39. Supervision of healthcare staff would be undertaken by other senior nurses and the clinical lead.

40. My clinical supervision was provided by senior nurses or the clinical lead towards the end of my time with G4S.

41. I found that clinical supervision did not always happen, it was sometimes difficult to get the time to do it. For example, you might not be on the same shifts as the person you were to provide supervision for. I found that the managers were really helpful when I was having to leave early for treatment and appointments.

42. When you need help on the floor, it can be hard to get a manager on the floor to assist. It would have improved things if they were more available to help.

Disciplinary and grievance processes

43. During my time at Brook House, I was subject to three disciplinary investigations due being absent as a result of my disability/illnesses. Disciplinary investigations would normally be undertaken by Michael Wells, the practice manager. I would have a disciplinary meeting and staff members would always ask how they could support me. Everyone was very accommodating but it was company policy that disciplinary investigations must be carried out for having such long periods of time off from work.

44. I wasn't involved in any grievance processes during my time in Brook House.

Staffing

45. There was always low staffing at Brook House in 2017. There were problems with getting staff in who were interested in working in that environment and the security clearance checks took a while. Brook House used agency staff a lot but even with the agency staff, I still felt that healthcare was understaffed.

46. I did have concerns about whether there were sufficient staffing resources to be able to provide adequate healthcare services to the individuals. Staff could have performed their role more efficiently and provided a better service if we had had more members of staff in place. We always raised the staffing issues in staff meetings. We knew they were trying to recruit.

47. There were approximately two thirds of permanent staff and one third of agency staff.

48. Most of the agency staff were from custodial backgrounds and were experienced in these environments.

49. A lot of the agency staff that were there started before I was joined. They used to use the same agency staff, so they were familiar with the centre and our processes. Sometimes they would not be in for a month and we would have to inform them of any changes.

50. Permanent members of staff were able to build better relationships with the detainees. Agency staff who attend the centre infrequently would find it harder to get to know the detainees and build up that level of trust with them. There was also a period when we had an influx of new agency staff. Other members of healthcare had to train them up and this was challenging, as it took up a lot of time when we were already very busy.

51. There were times when we had admissions coming in and if there were less staff then the walk in triage service potentially wouldn't occur. We would have to prioritise what needed to be done, for example if a First Response occurred during a triage clinic. There were times

when the healthcare staff weren't allowed to do admissions downstairs. We were constantly on the go and had a large workload, potentially this was as a result of low staffing levels.

52. When I started in 2014, morale was high. Slowly the nurses that were there at the beginning left and no nurses joined to replace them. Morale then became low.

53. Detention staff would always complain about staffing levels to healthcare staff. I used to do the talks to the new detention staff about healthcare and they were always recruiting every month. They would recruit new members of staff and they would not stay very long. There were times that I would go out onto the wing and ask for an escort to a particular room and I was told that they couldn't assist, as there was only one officer on the wing.

54. I don't know anything about staffing levels for the activities team.

Relationship between Healthcare and Detention Staff

55. The day to day working with the detention team in relation to the welfare of detained persons varied depending on the individual. Depending on the member of staff you were working with, I felt that I would not want to take up much of their time. It was not brilliant sometimes.

56. If I had any concerns regarding a particular detainee or a situation, detention staff would provide support. I never remember having any concerns regarding their involvement of the detention team in use of force incidents.

57. If a detainee required emergency care, we would call or radio the detention staff manager and inform them of the situation. Sometimes we would get pushback but a lot of the time, they were helpful. It is again, individual basis. They are not medical professionals, and it can be difficult for them to understand the severity of the situation so we have to make sure we make that clear.

58. I found detention staff's attitudes towards detainees to be professional. They were under a lot of pressure. They were looking after approximately 100 people on each wing and had a limited number of officers but they managed this situation well.

59. There were occasional issues between healthcare and detention staff. I don't think officers were very aware of the severity of some of the detainees' medical conditions. When a detainee didn't turn up to their healthcare appointment for example, we would call the officers on the wing and ask them to go and find the detainee. Sometimes officers would be reluctant to do this and complain that they were too busy. I don't think they understood how important it was that certain detainees attended these appointments, as they didn't have the appropriate

knowledge of the conditions. Most of the time healthcare and detention staff had a good working relationship.

60. There were times when I would press my call bell in healthcare and it would take a while for an officer to arrive. We are not security and there are no officers that are present specifically in healthcare. Occasionally the delay in their arrival caused me to feel unsafe.

61. There were times when specific instructions from healthcare staff would not be followed, for example a detainee was not brought for their medication or an appointment at a particular time, which made it difficult to provide the service we were aiming for.

62. It would be helpful to have a liaison officer that was based in healthcare but also spent time on the wing. This would help improve communications between healthcare and detention staff. Regular training sessions for officers in relation to main healthcare concerns such as alcohol and drugs training and withdrawals would also be helpful. Dental pain is a big problem throughout Brook House. Healthcare would have dental queries constantly and we did not have a dental suite. Regular training sessions for officers on dental issues would be helpful for staff. Officers also need to have a basic understanding of what to do when detainees are discharged from emergency services, as sometimes we would not be informed that certain detainees were back in the centre. We need to make sure that we are aware of any follow up appointments or changes to their medication.

Relationship with Home Office

63. I didn't have much contact with the Home Office. I attended formal meetings with the Home Office very rarely if Sandra could not attend. These meetings would be in relation to flights home for the detainees or adults at risk meetings. My relationship with the Home Office was not brilliant despite not having a lot of contact with them.

64. The only issue I experienced was Home Office contacting myself requesting amendments to the food and fluid forms when another professional has completed the form, and explained that I cannot change what the individual has documented.

65. There was quite low morale throughout healthcare as a result of the uncertainty surrounding the food and fluids forms. Nobody wanted to be the one to send them off because they didn't want the responsibility of missing the deadline to fall with them. We did not understand why the form was not correct, as we would not receive any feedback from the Home Office.

66. Our relationship with the Home Office did not impact healthcare's ability to fulfil their roles or provide adequate services to detainees.

67. It would be helpful to receive training on Home Office roles and policies. More knowledge about what they do would help us build a better relationship. More detailed feedback on the food and fluids forms would have been very beneficial.

Reception / Healthcare Screening / Induction

68. Detainees were usually health screened within two hours of their arrival into Brook House.

69. Health screening was a 24-hour service.

70. There were two rooms on the ground floor in the reception area where healthcare screening took place.

71. Any level of healthcare professional could carry out healthcare screening. It was usually a healthcare assistant. RGNs usually had to review their screenings and sign them off to confirm they had been checked.

72. If an interpreter was required, we would contact Language Line or Big Word.

73. We had leaflets that were offered to detainees. The leaflets were translated into a number of different languages, so detainees who did not speak English could also make use of them. They were put up onto the walls for detainees to take if they were interested. The leaflets contained medication times, healthcare opening hours and information on how to access the GP.

74. If the detainee came from another centre that used the same medical system as us, we could log on and gain access to the GP services with the detainee's details and obtain their medical records. Alternatively, we would speak to the detainee about filling out a form of authority and consenting to us having access to their medical records and send this through to the GP.

75. If an individual arrived with medication in their possession, we would first identify if the medication was labelled and in a box fully intact. We would have to ensure that the detainee's name was on it and it had definitely been prescribed to them. We would then have to conduct a further assessment and confirm that they are taking the medication correctly. The detainee would then be asked to sign an in possession medication compact form to confirm that they would not give their medication out to anyone else and would store it safely in line with G4S' policies.

76. If an individual arrived on medication but without it in their possession, what the process was for the prescription and dispensing of appropriate medication, we would need to confirm that they had definitely been prescribed the medication by accessing their medical records. The detainee would see the GP the following day and if it had been confirmed that they were using that medication regularly and the GP was happy to continue it, more could be ordered. If we were unable to access their medical records immediately, we would have to request them and following an assessment by the GP, it would be decided whether the detainee could have the medication now or whether we needed to wait for the medical records.

77. If an individual was suffering from a diagnosed physical health condition, the detainee would be seen by healthcare and we would gather more details about the physical health condition for example, how long it had been going on for and what medication they were taking. We would usually set a SLP up if necessary, so we can provide adequate support within the centre.

78. If an individual was suffering from a diagnosed mental health condition, we normally had mental health nurses in the centre every day. If a detainee was suffering from a mental health condition on admission, we would fill out a mental health referral form and pass it to the mental health team. If it was urgent then we would contact the RMNs directly and a further appointment for assessment would be arranged immediately. The RMNs could also refer on to the psychiatrist.

79. If we were concerned about a detainee's vulnerability then we would alert Sandra, who was the safeguarding lead. I would also alert an Oscar manager and highlight my concerns with reception staff. We have to sign a reception form when we finish screening new arrivals and if we have any concerns about any clients during reception, we can document this on the reception form for example, if we had opened an ACDT.

80. We would request that every detainee undertook a urine sample on arrival into Brook House. We would ask the detainee questions about their substance use, so we could ensure that we supported them with their physical withdrawals. We would try to get them an appointment with the GP as soon as they arrived. They could be placed on E-Wing if they needed a very high level of supervision and methadone would be prescribed if the GP thought it was necessary.

81. We would fill out an ACDT form if we felt that a detainee was at risk of self-harm or suicide. If the risk was not severe enough for an ACDT, we would schedule check-ins with the detainee to monitor their condition. Officers would also engage check-ins with detainees.

82. At one point the detainees wold stay on B Wing on the first night of their stay, which was an induction wing. I can't remember when that stopped and they started moving them around to different wings. Detainees had a buzzer in their room and they could press it to alert healthcare at any time. A nurse would attend the detainees' cell and treat them.

83. A GP appointment for the following day was arranged for every new detainee.

84. When I first started at Brook House, detainees were not automatically given a GP appointment for the following day after they arrived. We only scheduled GP appointments for those who we thought needed it.

Healthcare Facilities and Equipment

85. There were two physical observation rooms that had couches, observation equipment, equipment for canulatory emergency, emergency response – defibrillators, airways, observation equipment, emergency medication. There was equipment in the way of bandages, wound care, computers, pharmacy, medication, controlled drugs, and emergency medication.

86. In relation to mental health services, there was a talking therapy room, couch, and computer.

87. A lot of the detainees had dental issues and we did not have the facilities for that. As we didn't have a dental suite we had to send them to the emergency dental service. The clients used to become frustrated with this as they were in pain. In relation to other conditions, such as withdrawals from alcohol and drugs, it would be helpful to have the equipment there for them as we would always be chasing the equipment as it was being used elsewhere.

88. Healthcare staff should have had something in the emergency response bag for serious bleeds as we had to deal with quite a few lacerations.

89. I think the layout of the consultation rooms should be changed. They are designed so that the detainee is situated between you and the door. For safety reasons, I think the member of staff should be closest to the door in case of emergency. I once had an incident where a detainee threw a pair of scales at me as he was walking out. It was very distressing.

90. There is a definite lack of equipment in healthcare. On occasion, staff members would buy their own specific pieces of equipment to use, such as a pulse oximeter as there was such a shortage. There was only one pulse oximeter in the centre, so staff members tended to buy their own to ensure they had one in the event of a first response.

91. More equipment is definitely required throughout healthcare. Existing equipment should also be checked regularly for faults.

Access to Healthcare

92. In healthcare, there was a triage clinic every morning from 9:30 to 11:30 where detainees could attend without an appointment. Any appointments with the GP would need to be booked in advance. We also provided emergency care as required.

93. Mental health nurses were available to assess detainees who were struggling with their mental health. A psychiatrist also attended the centre once a week.

94. If a detainee needed to see a nurse, they would normally come to the triage clinic in the morning and discuss their concerns. We would refer them on to a mental health nurse or a GP if we saw fit. All new arrivals in Brook House would also be referred to the GP within 24 hours of entering the centre.

95. Appointments for detainees to see the GP set up by the RGNs following triage in the clinic.

96. If a detainee needed to see a RMN, they would come to triage in the morning and if we thought it was necessary or the detainee had specifically asked to see a RMN, we would fill out a mental health referral form and it would be passed on to the mental health team and they would arrange to see the detainee.

97. The detainee has to be seen by the mental health nurse first or the doctor for assessment before they are seen by the psychiatrist.

98. It was difficult if a large amount of people wanted healthcare access as only six were allowed in at a time. Sometimes they would not be willing to wait. During COVID we did not have the walk in service, a form had to be filled out describing their symptoms. The walk in service was more beneficial, as we would just get one word on the forms sometimes so there were some communication issues and it was difficult to provide adequate treatment.

99. Only six people were allowed in healthcare at one time, which sometimes caused delays.

100. There are no particular improvements in relation to accessing healthcare that I can think of.

Detained Persons

101. There were a lot of detainees suffering with dental pain in Brook House. There was also a lot of emergency care required in relation to altercations and new psychiatric substances. Mental

health was also a big issue with detainees, as a lot of them were suffering with depression and low mood.

102. The challenges for managing those health conditions were that there was no dental suite. It could be quite challenging trying to book appointments with the NHS as it could be a long winded process. We would need to do regular assessments of any detainees who had been involved in an altercation to ensure they are not suffering with concussion or head injury. If they need to go to hospital, it was challenging making sure we had the staffing to take them. It was also difficult to carry out the necessary observations of detainees who had taken Spice when we were understaffed.

Interpreters

103. Interpreters were used a lot in Brook House. They would be consistently available sometimes and then other times you could never get hold of them or they would be really unhelpful. Some languages were difficult to get interpreters for. We used Language Line and BigWord.

104. Most of the times interpreters were accessible. If you were phoning for a more common language then that would be fine but anything more unusual and there would be longer wait times.

105. We occasionally had staff members who could speak the same language as the client if interpreters were busy. This was not ideal as we wanted to use someone independent and more experienced in interpreting to ensure that we were getting the correct answers.

106. We need to make sure the information relayed is correct. If they are not relaying it correctly, it can impact the health we are providing. That's why we prefer to use official interpreters, as there is less chance of mistakes.

Supported Living Plan

107. SLPs were there to help certain detainees with health issues and assist them during their time at BH if they need any extra aid or support. SLPs make everyone in the centre aware of the extra help they will require.

108. If a detainee had a chronic or a long term health condition such as epilepsy, diabetes, mobility issues. We could also set SLPs up for short term conditions such as broken bones. Mental health conditions were also grounds for a SLP.

109. Anyone could set a SLP up. Staff would ask us to open them in healthcare and we had to remind them that anyone could set them up. We don't see detainees all the time whereas officers do, so they are sometimes better placed to open the SLP. We would tell officers to write it down, tell their manager and we would then arrange to bring the detainee to healthcare. SLPs get reviewed as and when. It depends on the detainee and the situation.

Complaints

110. There is a form on the wing that went to the Home Office for detainees to fill out. Home Office would then send down the written complaint to Sandra. Sandra would deal with complaint or ask senior nurses to deal with it on occasion.

111. I can't remember specific examples of complaints that I was involved in, as it was a long time ago now. I have done quite a few investigations with the complaints. From memory, we mostly received complaints about dental care. There was a huge lack of dental care in Brook House. We would have to explain that we were providing was emergency care, not necessarily routine care. I remember one client came from a prison to us and wanted his dentures completed and we don't do that here. The dentures had been started at the prison and we were trying to get hold of the paperwork for him, but we couldn't obtain anything at all. We sent him copies of everything to show we had been corresponding with the prison and they had no records. I can't remember what the outcome was.

E Wing

112. E-Wing usually contained detainees who were suffering from a substance misuse issue. Occasionally there would also be detainees in there who required support regarding their mental health or were refusing food and fluids. There would sometimes be detainees there who were disruptive and could not be kept on the normal wing with other detainees.

113. It was for detainees who required closer supervision and more constant support and monitoring.

114. A senior RMN would attend E-Wing daily and carry out ACDT and Rule 40 reviews. Healthcare staff would attend to administer medication if the detainees could not leave the wing at all.

115. The Care and Separation Unit was for detainees who have been severely disruptive, for example, jumping on the netting, damaging property or injuring other detainees or members of staff.

116. Healthcare used to attend CSU within 2 hours of the detainee being placed there to check in on them. The GPs would also attend CSU once a day.

Medication

117. Detainees would be risk assessed by healthcare with an in possession risk assessment form if they had been prescribed medication that could remain in their possession. We would check what medication they were taking, their previous history of self-harm and if they posed a risk to others. We needed to make sure there was no potential risk of overdose. This would be reviewed constantly. Once they have the medication in their possession, the pharmacy the

technician goes down to the detainees' cells approximately once a month and does spot checks and checks the medication is being taken correctly and is stored in locked cupboards.

118. We used to have medication times. Firstly we had 8-8:30 AM for controlled drugs. We would call the wing to remind the officers that the detainees needed to come up. We then had 8:30-9:15 general medications. Once that had been done, we used to document on the system who had and hadn't arrived. Lunchtime medications were from 1:30-2:15 in the afternoon. There was an evening controlled drug time and we then we had evening medication from 8:00-9:00 pm. If people didn't turn up three times in a row for medication then we used to send a request for them to come to healthcare for triage so we could discuss why they weren't coming and if they still didn't turn up then we would speak to the GP.

119. In the evenings, medication administration queues used to get quite busy and it would be stressful, there was only one nurse on shift.

120. More staffing is required in the evening.

Drug / alcohol misuse

121. Every detainee was required to undergo a urine test upon arrival into Brook House. If the detainees were on a prescription then we would request a prescription note from their pharmacy and ensure that they have been collecting their medication. Sometimes we would be alerted that a detainee is suffering with substance misuse issues before a detainee arrived at Brook House.

122. Healthcare would work together with the GP to discuss the next steps for the detainee in relation to treatment. A care plan or SLP would be implemented or methadone would be prescribed in some cases. We would arrange to check in on them throughout the night and provide any extra support they needed.

123. There was a psychosocial team in Brook House, the "Forward" team. I'm not sure if they held group or individual meetings but they were always there to assist the detainees.

124. I do not think the treatment available for detainees with substance misuse issues was adequate. I think it was too regimented and it didn't take the detainees' individual needs into account. Detainees were forced into getting help in Brook House. We would ensure that their levels of usage were decreased and but I don't think we implemented any long lasting changes.

125. A substance misuse specialist would have been helpful in Brook House. I think healthcare staff and wing staff could have benefited from sessions on how to best care for individuals suffering from substance misuse.

126. There was a large Spice outbreak in Brook House during the Relevant Period. There were a lot of emergency calls and everyone was extremely busy trying to manage their usual workload alongside attending the emergency call outs.

127. Healthcare would attend the emergency responses. We would assess the detainees and the officers would inform us of what had happened. Once we had carried out the initial observations, we could be providing immediate life support or phoning an ambulance. We would ensure that arrangements were made for the detainee to be closely monitored or in more severe cases they would be placed on E-Wing. Healthcare staff would attend E-Wing multiple times a day to check in on the detainee and administer their medication.

128. It was very distressing and even scary at times. Healthcare had to provide medical support to the detainee but we were under such heightened pressure, as we had to act very quickly. It was very stressful.

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

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

131. I never raised any concerns regarding the management of individuals who were intoxicated.

Mental Health

132. We had a mental health team which consisted of approximately one senior nurse and three or four or sometimes two RMNs. There were agency nurses who came in to support the mental health team sometimes. The RMNs used to do shift work. Senior RMNs were in Monday to Friday from 9am until 5pm. RMNs used to work throughout the week and they would undertake detainee assessments. Senior RMNs would attend ACDT assessments and undertake Rule 40 reviews and go and see any urgent cases that were required. Senior RMNs would also go and see those in the process of obtaining external support such as sectioning. There was also a healthcare assistant who would carry out checks on a lower level for detainees who only required lower level intervention. A psychiatrist also came in once a week.

133. I did not have any concerns about the appropriateness of healthcare staff's management of individuals who suffered from mental health conditions.

134. The officers weren't trained in mental health. I think more training was definitely required. Although RMNs came down every day to the wing to see certain detainees, it is not a mental health ward. More support was required.

135. In early 2018, I sent an e-mail to Head of Healthcare about how it was inappropriate for mentally ill detainees to be in E wing when suffering with mental health issues. They were deteriorating whilst being there and not receiving the help they needed.

Rule 35 reports

136. Only the GP can write Rule 35 reports. I was never involved in writing them.

137. A Rule 35 report is to identify if someone is being tortured or there is a risk of self-harm or deterioration inside the current setting that they're in.

138. A detainee would ask for a Rule 35 appointment and we would ask them to describe the situation in order to provide more information for the GP. They would then explain to us what was going on and the GP would see them and have a discussion with them around Rule 35. The discussion would be documented on the computer and the detainee would check it.

139. If a detainee was very vulnerable or had severe ongoing health issues, we would raise it with the Home Office and advise that we did not think they were fit to be in detention.

140. An assessment is carried out face to face with the GP. The length of time it took depended on the detainee and their situation. Sometimes they could last up to two hours. The detainee checks the report and signs it and it is then sent to Home Office.

141. Head of Healthcare was responsible for ensuring compliance with clinical standards and the effective implementation of the Rules 33-35 of the Detention Centre Rules safeguards.

142. Accessing an interpreter when you really needed one was difficult. Detainees also often believed that they required a Rule 35 report when they didn't. They would sometimes become confrontational.

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

144. I did not raise any concerns at any point about the process of assessment and writing of Rule 35 reports.

145. As nurses, we had to do all of the doctors' admin work. We had to send the paperwork off which consisted of a lot of printing and scanning. It would be much quicker to do this electronically. We were already very busy and this made us busier.

ACDT and self-harm risk management

146. I sometimes opened ACDTs for detainees and attended review meetings. Healthcare would report on the detainee's progress and help decide what else is needed to support the detainee.

147. Detainees sometimes self-declared. If a detainee came to us and said that they were having suicidal thoughts, we would immediately open an ACDT. If one of the officers on the wing had

identified a detainee who was in need of support regarding their mental health, they would be referred to healthcare for further assessment.

148. Healthcare would have an initial discussion with the detainee to find out how often they were having thoughts of self-harm or suicide and we would then open an ACDT. A full assessment of the individual would be conducted by an ACDT assessor and this would establish how often the detainee would need to be reviewed and what type of intervention was needed.

149. There would be regular reviews of the detainee's ACDT. Healthcare would attend these reviews in order to discuss the detainee's progress and what further support would be most beneficial to the client. Normally an Oscar manager would arrange the detainee's ACDT review.

150. 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.

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

152. If I had seen anything that concerned me, I would have raised it with my line manager at the time.

ACDT

153. The purpose of an ACDT document is to support certain detainees. It is a management plan with the aim of providing care and supervision to those who need it most. It ensures that the detainees' conditions are reviewed regularly.

154. If a detainee was suffering from thoughts of self-harm or suicide or was displaying any other signs of concerning behaviour for example, refusing food or fluids or suffering from consistent very low moods.

155. There was no threshold for opening an ACDT document. Anyone could open an ACDT if they thought it was necessary.

156. It would need to be discussed with an Oscar manager and the reasons for thinking one was necessary would need to be explained.

157. A detainee would first have an ACDT assessment undertaken by an ACDT assessor. From this assessment, it would be decided how often the detainee needed to be reviewed and observed. The assessor would put the next review date in the detainee's ACDT booklet and they would be further monitored in accordance with that date. Any changes in the detainee's behaviour would be noted down.

158. The initial review of the file is done straight after the detainee's first assessment. Healthcare staff, an Oscar manager, the detainee and the ACDT assessor would all attend the review meetings. We would discuss how we feel the detainee is and what further support is needed. We would set objectives in relation to that detainee and next steps to be undertaken. All ACDT booklets are checked daily by managers on the wings.

159. If the detainee no longer requires higher levels of support. Healthcare staff, the Oscar managers and the detainee must all be in agreement before the ACDT is closed.

160. Sometimes Oscar managers would ask why an ACDT had been opened and we would have to further explain our reasons.

161. Healthcare staff attended ACDT review meetings and had regular meetings with the detainee to monitor their condition. We were very involved in the management of individuals on ACDT documents.

162. Healthcare often would not be told about ACDT reviews until the last minute. We would receive a telephone call as the ACDT meeting was starting asking where we were. This made it very hard to organise your day.

163. During the week, a senior RMN attends all of the ACDT reviews. At the weekend it is difficult, as other members of healthcare staff need to fit them into their day and we are often not told in advance. It would be helpful to have a particular member of healthcare staff to consistently attend weekend reviews.

164. I attended Multi-Disciplinary Team meetings around three times. We would discuss detainees who were suffering from complex health issues. Healthcare staff didn't have to attend. The clinical lead would always be present.

165. I attended Safer Community Meetings and Adults at Risk meetings occasionally. If the clinical lead or Head of Healthcare could not attend then other members of healthcare would go in their place and be asked to report back regarding what was discussed. Detainees that had been identified as being at risk due to a certain health issue would be discussed in these meetings.

166. There was an employee care service for staff members to provide support to each other. There was an external service for detainees who had witnessed distressing events at Brook House. I didn't know much about this.

Food and Fluid Refusal

167. Healthcare staff would undertake the detainees' daily clinical observations if they were refusing food and fluids. We would ask when they had last eaten. We would assess their clinical symptoms and take their weight.

168. We would see the detainee once a day unless we were more concerned about their clinical symptoms. In this case, the detainee might require more constant supervision and sometimes detainees would be placed on E-Wing

169. Healthcare staff would need to complete food and fluid refusal forms. These would be sent to the Home Office.

170. I have had a number of experiences of detainees refusing food and fluids. On occasion, we had to start preparing for the detainee to be hospitalised. In these cases, we would have to ask the detainee if they wanted to sign a form called “advance decisions” which is similar 'do not resuscitate form.' It was very distressing to see.

171. I had some concerns about the appropriateness of the management of detainees refusing food or fluids. There were two forms that needed to be filled out by healthcare and sent to the Home Office. Sometimes Home Office would call healthcare and ask for certain parts of the form to be altered or changed, as they had been filled in incorrectly. There was no training on how to complete the forms and healthcare staff would worry about sending them off, as they always seemed to have been completed incorrectly.

172. Healthcare would raise any concerns regarding the detainee's during use of force incidents for example, if they had asthma then we would ensure that the wing staff knew they had to be careful not to block the detainee's airways when performing the use of force. Healthcare would attend to provide immediate medical support if necessary. We would ensure the use of force went ahead safely.

173. If the detainee has been violent or if they are destroying property then it is permitted to use force. If a detainee was resisting deportation then use of force could also be used or if they were trying to self-harm.

174. An injury to detainee form must be completed in order to identify if there had been any injuries sustained to the detainee. If the detainee went on a Rule 40 because of the control and restraint then we used to complete the Rule 40 paperwork.

175. Healthcare staff would have to assess a detainee within a 2-hour period following a use of force taking place.

176. I have been involved in the use of force on a detainee. If it was a planned use of force then a briefing meeting would be held beforehand. Healthcare staff would discuss any concerns we had in relation to the detainee's health. Every use of force I have been involved in has run smoothly and there have been no issues. I have never had to intervene or provide emergency medical care. I completed an injury to detainee form following this incident.

177. I have witnessed the use of force on a detainee many times. An injury to detainee form would always be completed.

178. Occasionally the detainee would be handed over to an external escorting team. I was unhappy with the way the escorting team were handling the detainees and I raised it with Head of Healthcare, Sandra. Sandra escalated it to the Home Office and it was decided that the external team were no longer able to perform use of force on detainees.

The Panorama Programme

179. I knew Callum Tulley but we did not work closely, as he was an officer on the wing. We would exchange pleasantries but that was it.

180. After re-watching the Panorama footage, I do not think that I appear in it at any point.

181. Everyone was very shocked and embarrassed by the footage. A lot of staff left. Everyone was very stressed and upset.

182. Leaflets were put under detainees' doors to tell them that they may be on the TV. We had to inform them, as they could have appeared on the footage. They were very angry and shocked. There was a mixture of responses but the majority of them were angry.

183. I don't remember being a part of the age dispute case on the Panorama footage but if someone is underage, we normally inform Head of Healthcare and inform the manager on site. Social services and the Home Office would also be informed and assessments carried out.

184. G4S put out a lot more information around the centre about how to access "Speak Out" the confidential telephone line which encouraged staff to raise any concerns. There was a lot more effort put into hiring officers to work on the wing.

Specific Individuals

185. I knew Nathan Ring just to say hello to within the centre. I can't remember him well enough to comment.

186. I didn't know Steve Webb, Kalvin Sanders, Derek Murphy, Dave Webb, Clayton Fraser, Charles Frances, Aaron Stokes, Mark Earl, Sean Sayers, Ryan Bromley, Daniel Small, Daniel Lake, Babatunde Fagbo or Shane Munro.

187. Chris Donnelly was one of the Oscar managers. If I had a detainee that needed escorting to hospital, I would ask Chris to organise this. He was very helpful. I had no concerns about him.

188. John Connolly conducted the Personal Protection training. I had no concerns about John. I didn't know him very well.

189. Slim Bassoud speaks another language, so was sometimes used as an interpreter. He was very professional and I never any issues with him.

190. I knew of Yan Paschali but didnt know him personally.

191. Jo Buss was very supportive of me. When I went from staff nurse to senior nurse, she was very supportive with that transition. She was always very professional and mentored me as I moved into my senior role. She was very supportive and I was shocked at the footage.

Suggestions for Improvements

192. I have included everything within my statement in relation to suggestions for improvement.

Any other Concerns

193. I have included everything within my statement in relation to concerns.

194. All staff members employed at Brook House will be knowledgeable of the matters mentioned in my statement.

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: 16/11/2021

Name: EMILY JAINE PARR