BROOK HOUSE INQUIRY

FIRST WITNESS STATEMENT OF LYN O'DOHERTY

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 23 September 2021. I have been authorised by G4S of 46 Gillingham Street, London SW1V 1HU to provide this witness statement.

I, Lyn O'Doherty, of DPA will say as follows:

Background

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

   My full name is Lyn Sharon O'Doherty and my date of birth is DPA

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

   I have been nursing for 40 years. I first qualified in 1985 from East Surrey hospital and spent the following year working in the Intensive Care Unit. I worked as a sister from 1986 to 1988 in Shirley Oaks. I then worked in Eastbourne District Hospital from 1988 to 1995 as a staff nurse and then a sister. I was an agency nurse between 2004 and 2010, I worked for Crawley PCT and the Borough Council as a fitness advisor. I worked as a health advisor at BUPA Gatwick from 2009 to 2010. In 2009 I became a bank nurse at G4S Brook House until September 2017 when I left to do a medical expedition and then I worked for Masta Travel Health from 2017 to 2020 as a lead clinician and CQC manager. I returned to Brook House on 26 November 2020 to work on the bank and I have done various agency nursing since then involving COVID, for example administering vaccinations. I am now a palliative care nurse.

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

   I worked at Brook House from 2009 to 2017 as a bank nurse. My hours were flexible and I could choose when I wanted to work. Brook House was my first experience working in a secure setting.

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

I left Brook House to do a medical expedition. I needed a change after all of those years working at Brook House. The environment got a bit intense. A lot of the residents had been transferred from prisons and there was a very aggressive feel to the centre. The residents were very demanding and there Spice was being used a lot by the residents. I was offered a job at Masta travel and took it. I only went back to Brook House because the pay had increased and there was a different feel. The centre seemed calmer and there didn't seem to be the 'rushing' around to so many medical emergencies (often Spice driven) or non-medical emergencies (arguments between residents) as before. Also there wasn't the banging on the healthcare door by residents that we had experienced in the past. This was not acceptable behaviour anyway as during out of clinic hours the residents were meant to ask an officer to make a request to be seen unless of course in an emergency as nurses had to complete other various tasks as well as admissions.

I'm not sure, but it could also be that the residents felt more settled in the environment. I noticed that there were more officers wearing 'Activities' t-shirts so the culture was perhaps moving to engage residents more to help them cope with detention rather than appear 'prison' like.

Application Process

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

I was mainly a stay at home mum and I wanted to try and get back into nursing. It was advertised in the papers as 'primary care nursing' and when I spoke with a lead nurse, it felt like there were a few things I could learn. The role seemed to be centred around dealing with chronic diseases as well as other health issues related mainly to asylum seekers, which sounded interesting and was local to where I was living at that time.

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

I think the recruitment process prepared me well for the role. I had good support from the nurses who had worked at Brook House for a long time. I shadowed them. There was always online training to maintain your skills.

Culture

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

The environment in Brook House was quite distinct. It was fine to begin with and then it got more intense with demands from the residents. You could easily identify who had arrived at the centre from prison. As a nurse, you try to treat everyone the same but when you're faced with

the aggression, my approach was always to de-escalate. There were a lot more control and restraints and there was a lot of Spice being taken by residents, which was de-motivating.

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

Healthcare staff were quite frustrated. I was being called out to various incidents, just troubleshooting. Morale was definitely not at its highest. I can't really say about the wing staff, as our main role was healthcare. We did get a bit frustrated and upset with all of the emergency call outs.

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

From a healthcare perspective, I think we did what we could to help the residents. I think people were still compassionate. I set up a better sleep clinic during the Relevant Period to help detainees with their sleep. I am a therapist as well, so I would often hold relaxation sessions. Staff would always try to find ways of calming things down. I think sometimes it was tense between officers and detainees. I can't comment on any particular time. I think officers were courteous to detainees. Officers may have complained about detainees following dealings with them but I did not witness any physical or verbal abuse.

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

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

I was shocked by the Panorama footage. I don't think it was a true reflection of what went on at Brook House. I was shocked by the physical abuse that seemed to have happened but I did not witness any of that. As a patient advocate, I would have said something if I had been aware of anything of that nature happening. Officers would complain but I did not ever witness any abuse. I did not have any concerns about how the residents were treated apart from one isolated incident. I thought one of the control and restraints seemed to be going on a bit too long, so I intervened and it was stopped.

b. The management of individuals with physical health conditions;

I personally remember a gentleman who had problems with his legs. He was a young man with huge legs and had told us that his uncle had looked after him previously. I said that in my opinion he was not fit for detention and then he was released. If we saw people who we felt were not fit for detention we would ask the GP to write a letter. I think that residents with physical health conditions were always managed well.

c. The management of individuals with mental health conditions;

Residents will often try to fake a mental health condition as they thought it meant they would be released from detention. We would still refer those residents to the mental health team. There is always a mental health nurse on shift. Residents' mental health was well looked after. If people needed time to chat, they could have all of the time they needed. There was never a time restriction on the sessions.

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

Sometimes if residents were bullied by other residents, we would be made aware of that by the officers. Clinics ran every day and we would ask residents if they were feeling vulnerable and refer them appropriately to the GP or various groups. I had no concerns about the management of vulnerable residents.

e. The management of individuals with substance misuse issues;

This was a new thing. Brook House started to become a substance misuse centre, I have never dealt with this before, so I felt uneasy. We went on a course regarding methadone and alcohol. It is managed and a GP issues the methadone. Nurses administer methadone every day, monitor the residents' symptoms and make sure it is being taken.

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

I had not seen any of this behaviour. I would have stopped the incident and escalated it higher by informing the detention staff manager if I had seen anything like that. I would have also informed my line manager.

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

No, I was not aware of this at all.

Oversight

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

i. The Independent Monitoring Board (IMB);

The IMB are a voluntary organisation. They would come in to Brook House and ask about the residents. I was reluctant to give information about residents, as we had to be careful not to breach medical in confidence rules. The IMB would ask about the health of certain people. I did not have a lot of contact with them. They were advocates of the residents.

ii. The Gatwick Detainees Welfare Group (GDWG);

I only contacted them by phone. They would ask about medication often and sometimes the residents did not understand that there could be a wait for medication. It often did not arrive until the day after a GP appointment.

iii. Medical Justice;

I did not have any contact with them. They helped residents with any legal aspects of their case.

iv. Bail for Immigration Detainees (BID).

If detainees are seeking bail, then BID are there to advise them on that and help them once they get bail. I did not have much contact with them.

v. And other external organisations.

I'm not aware of any other external organisations.

General Training

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

As a nurse, you must do continuous professional development. To some extent, you can decide what you need to work on. We get prompts to attend courses and have deadlines to complete them. We can do all of the safeguarding training online. Life support is face to face. Any face to face sessions are done yearly. We have fire safety training. Originally, when I started, it was not G4S healthcare who employed us, it was the local GPs Saxonbrook. Sometimes, we would go to the GP surgery to have training. I remember going to do a session about psychosomatic health.

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

I think it takes a certain personality to do this type of work. I did not anticipate so many ex-prisoners being in an immigration centre. In relation to clinical skills, I felt prepared but I was not prepared for the types of residents I was faced with.

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

Control and restraint training was essential. A good understanding was definitely needed.

16. What, if anything could be improved?

I think G4S have already made a lot of improvements over the years with the training. It is a very comprehensive training programme.

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

It was not refresher training, it was ongoing. When I returned to Brook House, they made sure that I attended life support training again. I don't think any other training courses should have been included. G4S covered everything.

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

G4S provided all of the training courses, even the ACDT training. Training was specific to this area of work, you would never see that in general hospitals.

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

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

I received control and restraint training in 2009 when I first started working at Brook House. I cannot remember ever receiving any refresher training. I did not ever keep records of control and restraint training.

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

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

(ii) Safeguarding Policy (CJS006379);

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

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

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

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

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

(viii) Any other specific healthcare training.

When I came back to Brook House in 2020. I did a day of training with Serco because they had taken over from G4S. I remember doing some ACDT training with them on 25 March 2021. It was originally scheduled for 26 November but that was cancelled and rearranged. I received ACDT training when I first started at Brook House in 2009 but I cannot recall the session nor do I have any documentation regarding it. I don't recall having any refresher training sessions until I started back at Brook House in 2020 however the healthcare admin team keep records of all staff training.

Staff Induction

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

When I first started working at Brook House in 2009, I spent a lot of time shadowing the manager and other staff. I was learning about the new systems and procedures. During my induction, I also worked night shifts and shadowed the nurses on night duty. In 2020 when I returned to Brook House, the induction seemed a lot more comprehensive. Brook House had changed a lot and was much bigger. There was a lot more training and more online sessions to complete. I was also updated on all of the different paperwork to be completed by healthcare. The induction lasted for about 4 shifts on both occasions.

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

I think the induction process did prepare me for my role at Brook House. It was very well-organised and thorough.

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

I don't think there were any problems with the staff induction process.

23. What, if anything, could be improved?

I think it would have been beneficial to spend more time with different departments during the induction period and understand more of what they do such as the wing staff and the Forward Trust team.

Management of healthcare staff

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

We had senior nurses, general nurses, regular nurses or bank nurses. I was a bank nurse and I ended up in charge of the floor. We had the GP doing clinics every day and in the office we had a practice manager and a line manager. Sandra Calver was my manager and Head of Healthcare. We also had a clinical lead and an admin assistant.

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

Healthcare assistants would report to me occasionally. Sometimes I was the nurse in charge of the shift, so they would be supervised by me.

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

My line manager was Sandra Calver. She was very approachable and I had a good relationship with her. She was easy to track down if you needed her on a shift, there would be a rota of who was in work that day. There was always somebody who you could telephone if you needed assistance. The amount of contact varied with who was in charge that day.

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

I received regular feedback. There was one instance where I received very good feedback. There was a lot of painting in the clinic room and I was still managing the clinic alongside it all. I managed to secure HIV medication for a detainee who was being released and got it to him before he went. I got a letter from the Practice Manager to thank me for dealing with it. I never got an appraisal as bank nurse. I didn't mind, as I knew what I needed to do. They have started appraising the bank nurses now. I think this started a few years ago.

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

I have always been able to rely on other healthcare staff. We work well as a team.

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

Clinical supervision always took place face to face. The supervisor would have a form to go through with us and we would answer questions.

30. Explain how your clinical supervision took place.

Jo Buss carried out my supervision. She was a senior nurse. Supervision was carried out every 3 months.

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

I never experienced any problems with my line management or clinical supervision.

32. What, if anything, could be improved?

It is important to know where people are if you need to contact them. A sheet has been created now.

Disciplinary and grievance processes

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

In relation to each example:

a. please provide approximate dates;

b. a description of the issue;

c. who was subject to the investigation;

d. what the investigation involved;

e. what the outcome of the investigation was;

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

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

I didn't have any involvement in disciplinary matters.

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

a. please provide approximate dates;

b. a description of the issue;

c. who was subject to the grievance;

d. what the investigation involved;

e. what the outcome of the investigation was:

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

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

I never had any involvement in any disciplinary or grievance procedures.

Staffing

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

There were lots of emergency call outs, which required more staffing to ensure that all services could still be offered. We generally had the right amount of staff for each shift. Agency staff were used when there were staff shortages.

36. In your opinion, were there, at all times, sufficient staffing resources to be able to provide adequate healthcare services to the individuals? Provide your opinion on whether the staffing levels in healthcare were of an adequate level to enable staff to perform all the functions of their role. If they were not, identify why not. Further, did you ever raise this at the time. Please provide details. If you did not, please explain why not.

I think there were enough staff for everyone to perform adequate roles. I remember the centre being understaffed on one occasion before the Relevant Period but this was an exception, this was not a regular occurrence.

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

We seemed to have agency staff working in Brook House most days. Usually bank staff wold fill in the gaps and then agency staff would be asked. I'm unsure of an actual proportion.

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

They were very experienced. A lot of them worked in prisons.

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

Agency staff were very good. They knew the procedures and systems well, as the same regular staff members were used to work in Brook House. I am not sure about the training agency staff received.

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

The number of agency staff did not affect the provision of healthcare to individuals. They carried out the role well. There may have been a bit of paperwork they did not know how to fill out but we would help them. Some of the agency nurses were trained in mental health as well, they were really efficient.

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

We always ran a clinic even though we might have been understaffed. If we were a man down, we would run one clinic room instead of two. Shortages never impacted the care and treatment of individuals.

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

Morale was sometimes low. If we were short staffed and everyone was really busy, it would be stressful.

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

I think detention staff often had one officer between two wings. I cannot be definite about this as we only attended the wings in an emergency.

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

I cannot comment on the staffing levels of the activities team. I am not sure.

Relationship between Healthcare and Detention Staff

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

a. Day to day working with the detention team in relation to the welfare of detained persons ;

We worked well with the detention staff. They would often refer detainees to us and ask to be kept informed on their progress.

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

This was not an area that I enjoyed. If it was use of force to remove somebody, it was effective. Healthcare would attend the briefing but the actual use of force was down to the detention team. We had no involvement other than to make sure the person was safe.

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

Communication was always good. Detention staff were very good at identifying detainees with medical issues and referring them on to us.

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

The Relevant Period was a stressful one. There were riots at one time. Officers didn't complain about detainees in front of them. Some would try and de-escalate the situation but other officers would be more assertive.

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

Detention staff didn't like it when we had to send people to hospital. They used to think detainees over exaggerated conditions occasionally. I don't think this was a huge problem. We generally got on very well and worked together as a team.

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

It didn't change my mind, if I thought somebody needed to go to hospital, they would go. I don't think this issue impacted morale or safety.

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

Not applicable.

49. What, if anything, could be improved?

I think staff members could have had a better understanding of different people's roles. It is a better atmosphere now than what it was. Brook House seems a lot calmer. I think this is partly due to a different mix of detainees, there hasn't been very many. The new officers should come to healthcare and see first-hand the pressure we are under, and vice versa. I think it would have been helpful on induction to spend a day with the officers and they spend a day with healthcare.

Relationship with Home Office

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

I did not have very much contact with Home Office staff. The only time I had contact with them was when they served moving directions.

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

I never experienced any issues with Home Office staff. I think more senior members of staff would contact the Home Office if that was required.

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

As above, I did not contact Home Office staff.

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

I don't think it had any impact of the ability of healthcare staff to fulfil their roles.

54. What, if anything, could be improved?

I can't think of anything that needed to be improved.

Reception / Healthcare Screening / Induction

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

a) How soon it was after arrival;

Detainees had to be screened within 2 hours of their arrival into Brook House. Once you have your resident you give them a leaflet on being at Brook House, we take basic details such as religion, we then ask them some questions regarding medical issues covering their appearance, psychological state, whether they have experienced any torture. We explain that there is healthcare access 24/7, and we touch upon any drug issues.

b) Whether it was during daytime or night-time;

Healthcare screening could take place at any time. It was a 24-hour service.

c) Where it took place;

Healthcare screening took place on the ground floor of Brook House in the admissions suite. Whilst it was still in a clinical room, screening did not take place in healthcare. Healthcare was on the first floor.

d) Who carried it out (what level of healthcare professional);

Usually a healthcare assistant carried out healthcare screening under the supervision of a RGN.

e) Whether the individuals had access to an interpreter if needed/requested;

Interpreters could always be accessed on the telephone if needed.

f) Whether the individuals were given any written materials concerning healthcare in Brook House;

Detainees were given a booklet on arrival in Brook House. This gave an outline of healthcare and we would also explain to the detainees where the healthcare suite was situated.

g) Whether healthcare staff had access to any previous medical records and if so the process for obtaining them;

Healthcare staff did have access to detainees' previous medical records. Sometimes they would be paper records or sometimes they would be on our computer system. A lot of different healthcare units use the same systems, so we share information through these systems, if permitted.

h) If an individual arrived with medication in their possession, what the process was for dealing with it;

We would make sure detainees were still able to have it in their possession if they were fit to do so. We would risk assess the detainee and ensure that they were not at risk of overdose and they would have to sign the in possession sheet to say they would not share the medication with anyone else. Detainees would be assessed at later dates to ensure there had been no changes in their ability to manage their own medication.

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

We would assess the individual and see how important the medication was for example, if it was heart medication we would arrange an appointment with the GP or consult him over the telephone if he was not on site. We have our own stock medication, so we would ensure that the detainee received their required dose if we had the medication available.

j) If an individual was suffering from a diagnosed physical health condition?

We would assess the detainee and arrange an appointment with the GP. Oscar 1 managers would also be alerted in order to make wing staff aware.

k) If an individual was suffering from a diagnosed mental health condition?

A RMN would be informed and they would conduct an assessment. The detainee would then be referred on to the psychiatrist if the RMN deemed it necessary.

l) If an individual was deemed to be vulnerable?

We would alert the admissions team and alert an Oscar 1 manager to ensure that there was appropriate support for the detainee.

m) If an individual was assessed as having a substance misuse issue?

Healthcare staff are usually made aware of any substance misuse issues before a detainee arrives at Brook House. Upon their arrival, we would arrange for a urine sample to be taken from the detainee and we would also consult the GP. If necessary, we would arrange for the detainee to stay in E Wing and we would monitor them more closely. E-Wing is a lot smaller and more support and supervision can be provided. If a detainee was using

methadone for example and it was controlled then they could be housed on the residential wing.

n) If an individual was assessed as being at risk of self-harm or suicide?

Officers would be informed immediately and an ACDT would be opened. We would ensure that when we had finished the admission process that measures had been put in place for the detainee to be closely monitored.

o) Where the individuals were accommodated for the first night or nights of their stay and what access there was to healthcare staff and services;

Detainees would be placed straight on the residential wing if appropriate. All detainees had 24 hour healthcare access. If the detainee needed assistance from healthcare at any time and it was not during triage hours, they would alert the officers who would then notify us. We would then arrange for the detainee to come to healthcare or we would go down to the wing.

p) What provision was there for individuals to healthcare staff to follow up following their first night in detention?

A GP appointment would be made for every detainee for the following day after they arrived in Brook House. In the meantime, if they required any assistance they could contact the nurses.

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

This was always standard procedure.

Healthcare Facilities and Equipment

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

a) Primary care services (physical health services);

There was an admin room, the pharmacy and two clinic rooms. The two clinic rooms were run by nurses and the doctor would also use them to do their consultations. The nurses' clinics would run for several hours in the morning and it would be an open door policy for detainees. We would triage them and do anything necessary for example, if they had chest pains and we thought they needed blood taken. We also had a couch and there was a screen for privacy. We would always ensure the door was closed to keep appointments private. There was a fully-fledged pharmacy where we would dispense the medication. We had cupboards full of dressings and other necessary equipment.

b) Mental health services.

Mental health services had a separate room along the corridor. It had comfortable chairs and a fish tank. It was a less of a clinical environment. They had their own way of working. This put the detainees at ease.

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

I think healthcare had the physical resources to deal with the health conditions individuals presented. If we did not have the resources, we would send detainees to the local hospitals. We did not need to send detainees to hospital often. If we suspected someone had broken a bone and needed an x-ray, they would be sent to hospital.

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

I think healthcare had the equipment to deal with the health conditions presented. For example, if someone was asthmatic and having an asthma attack, we would have more than just the asthma drugs. We would have oxygen and other equipment to fully treat the detainee.

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

I don't think there were any problems with the physical environment in healthcare.

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

We only had one ECG monitor, so we would have to ensure this was always checked to ensure it was working correctly. If it was not working, we would have to get another one from Tinsley House. This was not too much of an issue, as we would always anticipate if any equipment needed restocking.

62. What if anything, could be improved?

I can't think of anything that needs to be improved.

Access to Healthcare

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

i) Primary care (physical health) services;

As soon as a new detainee came into Brook House, we would assess them and ask if they were suffering with any physical health conditions. We would note down their answers for example, if they were suffering with asthma or diabetes. We would make sure they had any relevant medication. When COVID began, we would ensure new detainees did lateral flow tests as soon as they came in. I also started a sleep

programme to help detainees relax and get a good night's rest. Any wounds or infections that the detainees had would be monitored regularly. We also had access to specialist services, should they be required.

ii) Mental health services;

Mental health nurses would be in every day. If there were any severe issues then detainees would be referred to a psychiatrist. There was also sometimes a psychologist that came into the centre. The psychiatrist came in once a week but it could be more often if required. I think detainees were well looked after in relation to mental health.

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

i) Nurse;

We had a two hour clinic every morning. It was an open door policy and detainees could come without an appointment. If there were any emergencies, we would attend the wing with our emergency packs to treat detainees.

ii) GP;

Detainees would first be seen by a nurse and we would then decide if they needed to see a doctor. The GP was appointment based.

iii) Mental health nurse;

Detainees would have to be assessed by general nurses first and we would refer them on to the mental health nurses if required. Officers would often come to healthcare or phone us if they had any concerns about detainees' mental health.

iv) Psychiatrist/psychologist etc?

Mental health nurses would have to refer detainees on to the psychiatrist or psychologist.

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

In my view, there were no problems with individuals accessing healthcare. The detainees sometimes didn't get the answers they wanted for example, they would demand drugs that we could not prescribe them. This was not necessarily a problem. All detainees had access to healthcare.

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

I don't think there were any delays with individuals accessing healthcare. We had an open door policy, so the detainees could come and see us easily if there was an issue. The only minor delays were if there was a medical response we had to attend and we had to shut the clinic.

This would be temporarily. We would always take the detainees' names that were still waiting and offer to see them again in the afternoon. They always got a same day response.

67. What, if anything, could be improved?

I don't think any improvements could have been made.

Detained Persons

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

There was definitely a drug issue in Brook House. A lot of Spice was coming into the centre around this time. Spice would cause issues such as vomiting. We had a few detainees that we needed to send to hospital. There was also a lot of anxiety and stress caused by detention and this would manifest in the body causing a lot of headaches and other physical illnesses.

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

It was hard to manage the stress and anxiety and create a calming environment for people who are reactively depressed or stressed. People react differently and if you are in a place you don't want to be and fearing deportation then it is hard to calm down. There would also be outbreaks of aggression as a result. This would be difficult to manage.

Interpreters

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

We used BigWord telephone service in Brook House to access interpreters. When new arrivals into the centre were admitted, we would identify whether an interpreter was required.

71. Were interpreters readily available when needed?

Interpreters were always quite easy to access. There would sometimes be some difficulties at night but I never worked night shifts.

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

I did not experience any problems personally. I know that my colleagues experiences difficulty obtaining interpreters for more of the uncommon dialects.

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

I didn't experience any problems personally, so I am unsure on how they impacted the provisions of healthcare.

Supported Living Plan

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

If anybody needs support during their stay at Brook House then we would set up a SLP. This would make other staff members aware of the certain conditions and the extra assistance required. We would share this information with the detainees' consent. SLPs were reviewed monthly.

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

Detainees could have SLPs for long term and short term conditions. If a detainee had asthma or problems with their hearing or eyesight then a SLP would be set up. SLPs were more for physical conditions in my opinion. Any mental health issues would be closely monitored by the mental health team.

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

We would set the SLPs up initially and review them every month. Officers could open SLPs but we would need to be involved in the consultation process with the detainee.

Complaints

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

Detainees could complain to any senior member of staff. We had feedback forms that asked how detainees' visits were to healthcare and to rate them from positive to negative. There would often be complaints about medication. Detainees would complain about delays. Complaints could be made verbally and in writing. I have only ever dealt with verbal complaints, so I am unsure if there is a specific form that needs to be filled out.

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

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

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

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

I can't remember a specific example. I just remember that we used to receive complaints about delays in medication. I have never been involved in an investigation.

E Wing

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

If a detainee was a drug user for example, there were medical rooms on E-Wing so healthcare staff could closely observe these detainees. Those that were removed from association would need to be closely monitored. The GP would visit them daily. Healthcare would have to assess these detainees within a 2 hour window of them arriving at Brook House and specific documents needed to be completed.

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

To segregate them if they posed a threat to themselves or others or a potential threat was posed to them. Detainees would be housed on E-Wing if they were potentially underage or were at risk of self-harm, for example.

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

Healthcare ensured that detainees were not compromised in any way by being secluded in E-Wing. We would monitor detainees' mental health and ensure they were not distressed as a result of being removed from their normal wing. We would also administer their medication and provide emotional support, as they could not move freely.

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

If a detainee was particularly disruptive, violent, particularly vulnerable or just needed to be in a more secure unit then they would be placed in CSU.

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

Similarly to E-Wing, we were there to ensure that they were taking their medication at the correct times and to provide constant monitoring and emotional support.

Medication

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

We would assess the detainee to see if they were fit to have the medication in their possession. We would check they understood English and were not at risk of overdose. The GP would then see the detainee and check the medication. He would make sure that it was in date and the detainee would be reviewed every so often to ensure that it was still safe for them to have their medication in possession.

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

We administered medication three times a day from the pharmacy. We would administer it morning, afternoon and evening for around 45 minutes to an hour. If a detainee needed more medication than this in one day then their needs would be accommodated.

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

If emergency medication was needed, it would not arrive in the pharmacy until the next day. This was often problematic. We would get the emergency medication from Boots. We had a good relationship with them but sometimes detainees would become frustrated at the wait.

87. What, if anything, could be improved?

I don't think there were any huge improvements to be made. It was sometimes difficult to manage the expectations of the detainees but I don't think healthcare could have done anything differently.

Drug / alcohol misuse

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

If a new detainee was coming into Brook House and we were already aware that they had a substance misuse issue and it was not being managed, they would be sent to E-Wing. We would closely monitor them and give them medication to support their symptoms. If detainees were deemed stable, they could stay on the wings and GPs would assess them and distribute methadone accordingly.

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

Methadone along with other medication could be prescribed to detainees withdrawing from illicit substances. Staff would regularly check in with detainees and ascertain whether they required a referral to a RMN. We would provide emotional support and regular updated would be provided to officers, who would also closely monitor the detainees on the wing.

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

There was the Forward Trust team, healthcare team and specifically the RMNs, as they were familiar with dealing with detainees suffering from substance misuse.

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

I think all services and treatment available for individuals with substance misuse issues were adequate.

92. What, if anything, could be improved?

I am not too sure. This area was not my speciality. I think we handled it well.

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

There was a lot of Spice being distributed throughout the Centre during the Relevant Period. This caused a lot of disruption. There were constant emergency call outs and detainees would be very unwell. It was very distressing to see.

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

We would closely monitor the individuals. We would deal with the aftermath and attend the emergency responses.

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

It was very distressing. We would have to ensure that detainees were not left alone at any point. We would try to preserve the detainees dignity by concealing them as they were having an episode. We would keep them safe and comfortable and if necessary, send them to hospital.

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

I did not have any concerns.

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

I did not have any concerns.

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

Not applicable.

Mental Health

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

As primary health nurses, we can deal with stress and anxiety. We can help detainees talk through their problems and signpost them in the right direction in terms of further help if required. If detainees are suffering with a diagnosed mental health condition, this requires the expertise of the mental health team. We would refer the detainees to the mental health team and those who needed it, would have access to the psychiatrist. Anyone could refer detainees

to healthcare if they were concerned about their mental wellbeing. Detainees could also self-refer.

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

I never had any concerns. Everyone was doing the best they could and I thought all mental health conditions were managed well. If anyone was severely mentally unwell and was waiting to be sectioned for example, they would be moved onto a separate wing.

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

The officers were made aware of those detainees who had mental health conditions. I never had any concerns about their management. If officers thought a detainee was displaying signs of having mental health issues, they would refer them on to us.

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

I never raised any concerns.

Rule 35 reports

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

I was never involved in writing Rule 35 reports.

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

A Rule 35 report was for residents who had been victims of torture. It would prevent them from returning to the place of torture. It is a safeguarding measure. The purpose is to protect people who have come to seek asylum here and we make sure that they are safe and we acknowledge what has happened to them.

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

When new detainees were being admitted, we would ask them if they had suffered any issues and whether these were to do with torture or trafficking. If they answered yes, then we would ensure that they were seen by the GP who would carry out an assessment. The GP would spend a lot of time listening to the detainee's experience and he would make a note

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

People who are not physically and mentally well enough for detention cannot remain in Brook House. Healthcare often flagged certain detainees to Home Office and informed them that we

were unable to meet their needs and they would be referred on. For example, if a detainee was suffering from schizophrenia then they would need more specialist care.

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

Assessments are carried out face to face between the GP and the detainee. Sometimes an interpreter will also be present. The GP will sometimes check if there are any bodily injuries or scarring and he will make a note. Rule 35 assessments can take up to an hour. They are very thorough. A mental health assessment may also be carried out.

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

I think it would be the GP or Sandra Calver.

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

I did not face any challenges.

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

Not applicable.

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

Not applicable.

112. What, if anything could be improved?

I don't think there are any improvements to be made.

ACDT and self-harm risk management

113. Please refer to the following documents / policies:

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

ii) Safeguarding Policy (CJS006379);

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

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

I would occasionally attend ACDT reviews if there were no RMNs available. I would listen to how the detainee was feeling and offer healthcare support where necessary. If a detainee came

to healthcare with an open ACDT and required help in relation to a physical condition, I would assess them. I would make entries in their ACDT booklet to reflect that the detainee had been seen by me.

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

Detainees would come to healthcare and declare that they wanted to harm or kill themselves. We would chat to them and try to find out why they were feeling this way and what was causing it. Often it would be around the time of deportation and sometimes they would be self-harming. They were often very distressed and anxious. We would call a medical response and deal with any physical issues. We would then refer them on to the RMN for assessment and further treatment. Officers would sometimes identify detainees who appeared to be suffering from low mood and refer them to healthcare in order to be further assessed. Officers were a lot more familiar with the detainees, so they would recognise any changes in behaviour that may indicate the detainee was at risk.

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

Officers would refer detainees to healthcare or we would update officers about any detainees we thought were high risk. There would be a discussion with the detainee in healthcare and we would refer them to a RMN if necessary. Follow up sessions would be organised and we would ensure everyone in the centre was aware of the extra support this person needed.

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

We would always be informed about detainees who were at risk of self-harm or suicide but once we had referred them to a RMN, the RMN would manage them. The RMNs attended ACDT reviews, the RGNs only attended on occasion. We had a hand over every morning and evening and there was a sheet where we listed all of the detainees who were vulnerable or at risk, so everyone was aware.

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

I did not have any concerns.

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

I did not have any concerns.

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

Not applicable.

ACDT

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

An ACDT document was a shared document. It would be set up for any detainees that you thought were at risk or vulnerable in any way. We would open an ACDT and discuss it with officers and then contact would be made with the detainee to discuss further. It was to closely monitor certain individuals and ensure that they were getting the support required.

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

ACDT documents were for anyone who is deemed vulnerable for example, if someone was at risk of self-harm or if someone's behaviour had changed. In my experience, they were mainly for detainees at risk of self-harm or suicide.

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

I am not sure what the threshold was. On occasions, I would suggest opening one for certain detainees and after a discussion with other healthcare staff and Oscar 1 managers, it would be agreed that an ACDT was not necessary.

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

We would have to inform Oscar 1 managers and arrange a discussion. Oscars would know the detainees more than healthcare staff so they would often have the final decision regarding whether an ACDT should be opened.

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

Detainees could still reside on the wings with an ACDT document. It would be agreed with the detainee how many check-ins a day were necessary. If someone was feeling particularly down or low then 3 or 4 check-ins may be pencilled in. There always had to be enough contact to closely monitor the detainee.

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

The review process was very case specific and it depended on the detainee. Detainees who needed more support would require constant reviews to see if more meetings were required etc. It would always be assessed on a personal basis.

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

When the individual was in agreement and things had improved for their situation, they felt better about things. The ACDT would not be closed without their consent.

127. How could an ACDT be challenged?

A discussion would have to be arranged with healthcare and Oscar managers.

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

If at any time the detainees needed to see healthcare, they would come for an assessment. We would then write in their book that we had seen them and what was discussed. This could then form one of their conversations that needed to be had daily. Healthcare staff could also attend ACDT meetings.

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

I did not encounter any problems.

130. What, if anything, could be improved?

I can't think of any improvements. I thought everyone was very efficient and ACDTs were always managed well.

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

I cannot remember. I think I did attend. We would have discussed any improvements to be made to our service. I don't recall these meetings being in relation to specific individuals, it was more about healthcare's performance and audits etc.

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

I did not attend personally. We would receive minutes of the meetings but we would never be required to attend.

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

Officers would always be there to help detainees and they could also come to healthcare to talk. I don't know of anything that was formally in place but if it was requested by a detainee, then counselling could have definitely been arranged.

Food and Fluid Refusal

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

As soon healthcare were notified by officers that a detainee was refusing food or fluids, we would monitor them closely daily. If more than 3 days had passed since the detainee took food from the servery or bought food from the shop, an ACDT would be opened for the detainee. We would go to see the detainee and carry out a physical assessment. We would weigh them and talk to them about why they were refusing food and water.

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

We would see them every day. If a detainee got worse, we would transfer them to E-Wing for close observation. At this point, the GP would be involved and the detainee would be put on ACDT review. In extreme cases, the detainee would be transferred to hospital.

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

Annex A and B sheets needed to be submitted by 12pm every day to Oscar managers to inform them of the progress detainees had made. We would add entries into their ACDT booklets. GPs would see the detainees every day.

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

I have been involved in a food and fluids case whereby we had to send the detainee to hospital, as they were refusing all help from healthcare and the GP. It was very distressing.

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

I had no concerns. There were very clear guidelines about how to manage these individuals.

Use of Force

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

Healthcare staff have to attend use of force incidents. We ensure that the health of the detainee is not comprised in any way for example, if a detainee has asthma then we ensure that their airways always remain clear during the restraint. There is often a briefing held prior to a use of force and healthcare staff attend. We alert the officers to any health conditions and ensure that the welfare of the detainee is taken into account.

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

When a detainee is being disruptive to the centre and is compromising other people's safety or their own.

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

A use of force form would have to be completed. Notes of any assessments would also have to be recorded to make a note of their injuries.

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

Detainees must be re-assessed by healthcare within 2 hours of use of force being carried out on them. We would assess for any bruising and cuts and provide further treatment.

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

I have been involved in a use of force incident. My role is to stand back and observe and ask officers to stop if I think the detainee is in any danger. I always complete a use of force form following any involvement in these incidents.

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

I have witnessed a use of force incident. There was a time when I thought the restraint was going on for too long and I asked the officers to stop. They stopped immediately. I completed a use of force form afterwards.

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

I have never had any concerns. The one time I asked officers to stop, they stopped. They were always very professional.

The Panorama Programme

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

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

I recognised Callum but I can't recall ever working with him. I don't think he was there long and I was not there on a regular basis.

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

I do not appear on the footage.

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

I had left Brook House at this point, so I am unsure of the impact it had on staff morale.

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

I was not working at Brook House during this period.

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

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

I was not involved. I know that social services would be called and I am not sure what happens beyond that. I think an assessment is carried out.

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

I am not sure.

Specific Individuals

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

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

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

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

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

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

a. Nathan Ring I recognised Nathan but I have never had much interaction with him. I never had any concerns.

b. ***Steve Webb*** - No

c. ***Chris Donnelly -*** Chris was an Oscar manager. I didn't know him very well. I didn't have any concerns.

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

e. Derek Murphy I don't know this person.

f. John Connolly - I know who John is but I did not know him well.

g. Dave Webb I don't know this person.

h. Clayton Fraser I don't know this person.

i. Charles Frances I don't know this person.

j. Aaron Stokes I don't know this person.

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

l. ***Slim Bassoud -*** I always found Slim very helpful. He was always professional and I did not have any concerns.

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

n. Ryan Bromley I don't know this person.

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

p. Yan Paschali I don't know this person.

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

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

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

t. ***Nurse Jo Buss -*** I worked closely with Jo on occasions. I never had any concerns about her behaviour or her conduct. She was a very experienced nurse with so much knowledge. I really looked up to her. She would go above and beyond to assist the detainees. She was very kind.

Suggestions for Improvements

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

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

I do not think there are any changes to be made.

Any other Concerns

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

I have covered all relevant information in this statement.

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

All healthcare staff who were employed at Brook House at the same time.

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

Not applicable.

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: 29/09/2021

Name: Lyn O'Doherty