BROOK HOUSE INQUIRY

FIRST WITNESS STATEMENT OF JACINTHA DIX

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 4 October 2021 .

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

I, Jacintha Dix, of DPA, will say as follows:

Background

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

   My name is Jacintha Louise Dix and my date of birth is DPA

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

   I started work at Brook House as a cleaner in 2009 by a company called Aramark. I was interviewed for a role as Healthcare Assistant in the healthcare department owned by Saxonbrook in 2011 and got the job. I was then promoted to Practice Manager in May 2012. I am still the Healthcare Practice Manager at the Gatwick Immigration Removal Centres. In terms of qualifications, I have some GCSEs and AS levels and I am currently studying for my level 5 diploma in Leadership and Management.

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?***

   As I have detailed at question 2 above, I started work at Brook House as a cleaner in 2009. I became a Healthcare Assistant in 2011 and was promoted to Practice Manager in May 2012, which is the role I am still employed in at present. The Practice Manager role technically covered both sites, but in practice I was based at Tinsley House but I would cover for the other practice manager if he was off. As a Practice Manager I work standard office hours, Monday to Friday.

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

I was employed by G4S as a Healthcare Practice Manager for the Gatwick IRCs until September 2021, when the contract moved over to Practice Plus Group and I was TUPE transferred over to Practice Plus Group.

Application Process

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

When I first started work at Brook House as a cleaner I needed employment close to home. I have always been interested in working in a healthcare setting as I am a caring person and wanted to help people if could.

The Practice Manager role did not exist when I first started at Brook House. The role was created when I was working as a healthcare assistant. At first there was only one Practice Manager but during the time of the Panorama filming there was two Practice Managers, myself based at Tinsley and Michael Wells based at Brook.

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

When I first joined I was part of a group of people and the site was a building site at first. We did a couple of days based in a classroom where we did self-harm ACDT, personal protection training for working in a secure establishment. I don't think the recruitment process prepared me for the role. I don't think anyone could be fully prepared until you are working there as it is so different and diverse. Even starting work as a cleaner it was a very different environment to anywhere else I had worked before.

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.

It is a diverse, new and different environment and is different in healthcare from on the wing. Because of the high number of throughput of patients, it is ever changing and can be difficult to remember what the culture was like. Every day was and is different, some days seems somewhat quiet, but this can change instantly. It can very busy with lots of first responses (emergency responses) and admissions and discharges. It could be quite volatile at times and we would have a period of calm before the storm then all of a sudden, it would erupt. A lot depends on nationalities of detainees arriving at the centre and we do notice trends.

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.

I remember that when we moved over to G4S staff morale was low as staffing was not fully recruited and this put extra pressure on the nursing staff. It can be a difficult environment to work in. I had no idea anything untoward was happening. After Panorama aired it had a negative impact as staff felt watched and were scared to do anything or make any decisions.

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

In my opinion staff from healthcare are really caring and didn't look at patients as criminals, they just helped them as we could with their care. After Panorama nurses were taken aback and I think they were disjointed from the patients and didn't want to do the wrong thing so people were nervous and scared. I didn't see any untoward behaviour from nursing staff or officers, they were all good and caring.

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;*** - from a healthcare point of view I no concerns about how patients were treated. I believe that in 2017 the Home Office were keeping patients for longer period of time rather than the centre being used as short term holding facility, which was a worry but there nothing we could do about this other than to raise our concerns to our management and they raised this with the Home Office.

b. ***The management of individuals with physical health conditions;*** If a patient did have severe health problems we would alert the Home Office as soon as possible as we don't have facilities to cater for patients who are disabled or require social care. Our nurses are not trained to cover social care.

c. ***The management of individuals with mental health conditions;*** We had a good mental health team and good processes that started from admission to the centre. If we were concerned the patient would be referred to mental health and then on to the GP or psychiatrist if appropriate. The psychiatrist would come in and see them weekly and send them out to secure mental health facilities if necessary. I was involved in a couple of s48 referrals to a secure mental health facility. I remember we looked after the patient as best we could until they were transferred out. The mental health team are on site 7 days a week so they would check on the patient's welfare every day. At the time of the Panorama I do not think we had a Senior Mental health post in place but now we have this position.

d. ***The management of individuals who could be considered vulnerable;*** I can't remember when it started we do an adults at risk multi-disciplinary team meetings with healthcare, Security, the Home Office and other people like the IMB attend. We discuss any patients we believe are vulnerable and that is escalated to the Home Office and their case worker decides if further action should be taken.

e. ***The management of individuals with substance misuse issues;*** I had no concerns. Our substance misuse processes have improved over the years. We have substance misuse facilities and the doctor and nurses can give methadone to support the patient. I can't remember when they joined us, but we also work with the Forward Trust who used to be separate to healthcare (now we are one big team), to support individuals with substance misuse issues.

f. ***The protection of specific individuals from the type of abuse seen on the Panorama programme.*** I wasn't aware anything like this was happening. I was aware of patients who had come out of prison having committed serious offences being detained with people who had arrived in the country without proper certificates but had been living peacefully in the community. It was widely known that we were worried about putting those two groups of people together. I was told the Home Office looked at room allocations and worked with the security teams and to make sure vulnerable people were not put in same room as someone who had been convicted of a crime and spent time in prison.

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 "whistle blower" and the response to it and the reaction from detention staff management and healthcare staff management.

I can't remember any occasions when concerns were raised by a member of staff. If I was concerned about something I would raise it with the Head of Healthcare Sandra Calver and they would raise it with the Home Office. I've never had to do that.

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)***; for me their role is to be the patients advocate and look out for their welfare, healthcare, security and safety. I did have quite a lot of contact with IMB at Tinsley House, as they would come to me if they had questions about patients. We had an IMB group for each site, Brook House and Tinsley House. The IMB used to come to me directly if patients had any feedback, compliments or complaints. I used to speak to patients one to one and deal with any complaints and do monthly patient engagement meetings at Tinsley House, which the IMB were invited to and attended. I also attended the IMB monthly meeting at Tinsley House as the healthcare representative. I didn't have as much contact with the IMB at Brook House as I was the Practice Manager for Tinsley House.

ii. ***The Gatwick Detainees Welfare Group (GDWG);*** As far as I am aware they are there for the patients if they need help with things like access to solicitors, clothing and things like that. I didn't really have much contact with them except for if a patient came to healthcare and asked for solicitors I would send them to the welfare team.

iii. ***Medical Justice***; I get a lot of requests from Medical Justice to see patients. I used to book rooms for the doctor from Medical Justice to come in and assess the patient to then prepare their report. I didn't deal with them individually but set up the meetings and passed on reports.

iv. ***Bail for Immigration Detainees (BID).*** They are another organisation for the patients and dealt with any bail queries. I did not have any dealings with them at all.

v. ***And other external organisations.*** I can't think of any other external organisations that I had contact with at the centre.

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.

When I started as a cleaner in 2009 I remember attending a full day training with all departments at the centre. The secure organisation who had the contract for the centre at the time ran training which included self-harm and suicide and personal protection training. When I moved to the healthcare team, there was a lot more mandatory training, including safeguarding level 2 and 3 covering adults and child and immediate life support, manual handling and fire training. I also did training on leadership and management provided by G4S, which covered disciplinary processes, absence and payroll.

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.

It was very hard to prepare myself or anyone for a role in a detention centre or secure setting as you cannot go onto site before you start. Many staff come for interview but working on site in confined locked no window environment is difficult. If you could see what it's like, familiarise yourself by being a visitor and buddy up with someone you could prepare yourself for your first day.

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

My job role is more office based so communication, rota management, payroll and recruitment are all areas that are essential and which you learn on the job. Leadership and management helps.

16. What, if anything could be improved?

Everyone should do self-harm and safeguarding training even if you are not patient facing so you have an awareness of the issues to look out for.

Serco now do two modules of online training in self-harm awareness and suicide prevention, which is refreshed every year. Personal protection and health and safety training was a one off training session and is now a yearly refresher. Adults at risk training was not embedded as well as it is now.

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

I don't remember any refresher training in 2017. In my opinion self-harm awareness, ACDT, safeguarding, management training, health and safety and personal protection training should all be done annually.

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

There are no other courses I can remember in addition to those I've already mentioned.

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:***

a. 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 did not receive any training on use of force. I received personal protection training in 2009, which lasted one day. I did not receive any refresher training.

b. 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 did not receive any Rule 35 training. I received ACDT training when I first started working at Brook House in 2009. I did not receive any refresher training.

(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.***

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 began working at Brook House in 2009 as a cleaner, I do not remember receiving an induction. In 2011 when I moved to Saxonbrook, I received an induction and completed all of the mandatory training courses such as immediate life support training.

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

I did not feel very well prepared for my role at Brook House. I would have liked to receive a more formal, thorough induction in 2009 as I did not feel prepared for the environment. Even as a cleaner, you still need to be aware of anything untoward for staff and patients and their vulnerabilities.

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

I do not remember receiving one however if I did it would have been regarding cleaning only.

23. What, if anything, could be improved?

All members of staff should receive the same induction when starting work at Brook House. It is important that people feel well-equipped to work in secure settings.

Management of healthcare staff

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

Sandra Calver was Head of Healthcare and my line manager. Chrissie Williams was the Clinical Lead, and Jo Buss was promoted from a Senior Nurse to Clinical Lead for Tinsley House in April 2017. Michael Wells was the other Practice Manager and was based at Brook House, I was based at Tinsley House. Michael and I line managed the administration team.

Sandra managed the clinical leads; they managed the senior nurses who in turn managed the nurses, health care assistants and the pharmacy technician.

This included the mental health nurses. I don't think we had a senior mental health lead at the time but we do now.

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

In 2017 we only had one administration assistant, Pamela Neal Bowers, who was based at Brook House so Michael would line manage her but it was both our joint duty. We now have four admin assistants.

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

I report in to Sandra and have a good relationship with her. We communicate every single day. She always picks up her phone even if on annual leave or working all weekend. It is very easy to get hold of her. If she is on site she would usually be in the office at Brook House sitting side by side with Michael and Pam and the clinical lead.

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.

Sandra Calver is my manager. We have employment development reviews yearly, which are usually opened in January and have interim meeting and close it at the end of the year. I have monthly one to ones with her as well. I have a really good working relationship with Sandra. She is very supportive, very hard working and really experienced, she knows all the answers and if I am ever stuck for anything I always go to Sandra and she knows how to do it. My employment will transfer over to Practice Plus Group on 1 September 2021, when they take over the healthcare contract from G4S.

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.

Yes we always had a good team, sometimes there might be one or two people who need performance management. If a staff member is not meeting the needs of their role they are provided training and support but if still do not meet the needs it is not the right job for them. Overall I feel supported by the healthcare team.

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

Clinical supervision is provided by the clinical lead who does one to ones every month. I would have helped booking appointments but I would not do the one to ones.

30. Explain how your clinical supervision took place

I do not have clinical supervision as I am not a member of the clinical team.

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

Not applicable regarding clinical supervision. I have had no problems with my line management.

32. What, if anything, could be improved?

Sandra does so much, it would be good if she had more support.

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 have done some disciplinary hearings and investigations. I can't remember when they were and I was helping out with Yarl's Wood as well at some point.

The Gatwick IRC disciplinary matters were about performance management absence. If a staff member hits is absent from work on three or more occasions during a 12-month period they hit a trigger for absence. They have a return to work meeting for each absence and on the third occasion, there will be an informal meeting to confirm that the level of absence is not acceptable. There will then be a formal meeting to discuss the absences and establish if there are any underlying issues or mitigating reasons. The outcome would normally be a performance review or a performance improvement programme to try to support them to avoid any further absence. I had to follow this process with the administrator at Tinsley House and ultimately she left the business, as she couldn't meet the business need at the time for her to work standard office hours Monday to Friday.

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

As far as I am aware I have never been the subject of a grievance.

I think there was a grievance about Sandra, but I can't remember what year it was. From memory I think there was an issue with a member of staff who was in conflict with Sandra. I don't know the details of this or the outcome.

Staffing

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

We were short staffed with the permanent staff, but the shortfall was covered by overtime from our permanent staff, bank workers and our agency staff, which would be the same agency staff, so the continuation of care would still be there.

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.

Yes. I believe so. It was only when untoward things happened, for example when there was an increase in medical responses, or when they started doing charter flights and lot of patients would self-harm, that there was extra pressure on the team. This happened quite a lot but we couldn't plan for it as did not know when it would be. There was also staff absences that were unforces due to sickness.

I think we had adequate levels of staff to perform the functions of the job.

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

I am not sure of the precise proportions, but I would estimate 30-40% agency.

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

Yes all agency staff came from prisons or secure environments. They all had previous experience and all had the training. The agency team would provide us with evidence that the staff had had all of the necessary training.

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 would have on the job learning. They were given an orientation pack and worked with permanent staff member on the job. They had training on ACDT, key talks and Systemone training. They would learn the policies on the job.

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

No, I don't think so.

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

I don't think any services were not upheld because of shortages of permanent healthcare staff as those gaps were covered by agency staff, bank staff or overtime. If services were not able to go ahead it would be because of other reasons for example if there was a riot in the centre.

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

I think staff morale was lower than it would have been if we had been fully staffed with permanent members of staff. We have a really good agency team, but it isn't the same as having a full team of permanent staff.

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

In my opinion there was a high turnover of detention staff. A lot of the officers seemed to be young and naïve and have no prior experience of a secure setting. Many had come from education straight into this as first job, which I don't think is a good idea.

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

I can't really comment on this. I think sometimes perhaps they didn't have enough staff.

Relationship between Healthcare and Detention Staff

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

a. ***Day to day working with the detention team in relation to the welfare of detained persons*** ; I think the day to day working was good. We were able to communicate with the detention staff and we worked as a team. We had meetings with them and other organisations and they would help us with getting patients out to hospital etc.

b. ***Effectiveness of involvement of the detention team in use of force incidents***; I feel like we had to make sure the healthcare staff had more confidence to ensure they felt able to voice their opinion regarding patient safety when dealing with control and restraint. We have always said that if they are not sure if the patient is safe then they need to stop it. We were mindful that it could be quite overwhelming with fully kitted up security team and one nurse. I can't remember if these issues were raised before or after Panorama but it was definitely around that time. I remember staff saying they didn't always feel comfortable saying anything and we encouraged them to raise their voice to say stop.

c. ***Communication with detention staff about any individuals with ongoing medical needs;*** I think this was good as well. We complete part C's if we are concerned we write on the part C and that goes to the Home Office and they share that with Home Office case worker and share with detention staff if relevant. We always let them know about our concerns but whether they listened or took action was out of our hands.

d. ***Attitude of detention staff towards detained persons (provide any specific examples you are able to recall);*** when I watched the Panorama programme I was absolutely shocked I didn't realise that kind of behaviour was going on. I didn't see any behaviour like that at all. I thought the officers were ok with patients, their attitude was good. I was mainly be in the healthcare department and we might have officer with us, but I did not really spend much time on the wings.

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

No, I don't remember any.

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

Not applicable.

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?

We don't have any team bonding. At the beginning we all used to the training together. It would improve relationships if the healthcare and detention staff were to do that.

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 was based at Tinsley House and I dealt with the Home Office there rather than at Brook House. I didn't really have any contact with the Home Office when I was at Brook House. In my opinion some of the patients were kept too long and it didn't help their mental health. That has changed and improved after Panorama.

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

There were a few issues sometimes when the Home Office would allocate some patients to us who would come without any medical history and would be withdrawing or HIV positive but without any medication; some patients would come without anything so we couldn't support them at the first point. Sometimes we had patients who were alcoholics and they might arrive under the influence. I can't remember if this was in 2017 or not, but healthcare would say that we needed more information or that we didn't want to take a patient and set out what we believed was correct, but the Home Office would overrule us and we would have to take patient anyway. It was difficult sometimes as the Home Office would send us a request for information and need a response within an hour, and the healthcare team would have to scramble together to get everything that was needed for discharge. The Home Office tell us what has to happen and we have to try to accommodate this but it can put extra pressure on the team.

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

I think that healthcare staff felt like they are not listened to by the Home Office as when we voice our opinions the Home Office would still bring the patient. This created low morale because couldn't do as much as wanted to care for the patient.

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 think the Home Office could have done more. They don't keep the detainees at the centre for long periods of time now, so that has improved. I think these issues did make healthcare staff feel like what they said didn't really matter. If we raise a concern that someone is vulnerable the Home Office do seem to act on it quicker now but if they want to bring in patients we still get overruled. This happens very rarely now and the patient doesn't stay for long.

54. What, if anything, could be improved?

Communication could be improved and if healthcare could be told a patient is being released before the patient is told we could make sure the patient is ready to go. We can also make arrangements with healthcare providers in the community to ensure continuation of care.

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;*** Patients were to be seen by healthcare within two hours of arrival into Brook House.

b) ***Whether it was during daytime or night-time;*** Health screening was a 24-hour service.

c) ***Where it took place;*** Healthcare screening took place within three clinical rooms in reception.

d) ***Who carried it out (what level of healthcare professional);*** Either a healthcare assistant or a trained nurse would carry out healthcare screening. All admissions completed by Healthcare Assistants waere checked and signed off by the trained nurse.

e) ***Whether the individuals had access to an interpreter if needed/requested;*** Patients would have access to an interpreter if they required one. During the Relevant Period we used Big Word

f) ***Whether the individuals were given any written materials concerning healthcare in Brook House;*** All new patients were given a leaflet containing information about healthcare. The leaflet contained medication times, how to access the clinic and other useful information. This was also available in different languages.

g) ***Whether healthcare staff had access to any previous medical records and if so the process for obtaining them;*** It depends where the patients was arriving from. If the patient came from a prison then staff would have been given the paper medical notes. If we did not have the patients' medical records, we would ask the patient to provide the details and sign a consent form to grant us access.

h) ***If an individual arrived with medication in their possession, what the process was for dealing with it;*** The patient would be individually in-possession risk-assessed to see if they were able to have the medication in their possession, this was encouraged. If the patient needed mediation he GP would make the decision and prescribe it. Some medications were never permitted to be in the possession of a detainee if they could have a highly-tradable value within the centre. These would always have to be distributed from the medication hatch.

i) ***If an individual arrived on medication but without it in their possession, what the process was for the prescription and dispensing of appropriate medication;*** The doctor would assess the patient and review their medical records to ensure that they had been prescribed the medication previously. If the doctor was happy to prescribe it then we would contact Boots and they would deliver the medication the next day or the same day if urgent.

j) ***If an individual was suffering from a diagnosed physical health condition?*** The action taken would depend on the severity of the physical health condition. If the physical health condition was too severe for us to manage within the centre, then we would not be able to take the patient. If we were able to admit the patient, we would set up a SLP and notify staff of the patient's specific needs.

k) ***If an individual was suffering from a diagnosed mental health condition?*** The patient would be referred to a RMN to be assessed. The RMN would refer them to the doctor or psychiatrist if they deemed it necessary. In severe cases the detainee may be sectioned under Section 48 and sent to an alternative medical facility.

l) ***If an individual was deemed to be vulnerable?*** Healthcare had adult at risk meetings where we would discuss any patients we were concerned about in relation to vulnerability. We could place the patient on an ACDT or SLP and monitor them closely.

m) ***If an individual was assessed as having a substance misuse issue?*** The patient would be referred to our substance misuse team. The team used to be called Forward Trust and before that RAPT. They would provide support and check in with the detainee to monitor their progress. We also had a pharmacy and doctors on site who could put the patients on a detox.

n) ***If an individual was assessed as being at risk of self-harm or suicide?*** The patient would be put on an ACDT and we would inform the managers and security of their condition that they need to know. We would hold multi-disciplinary team meetings and collectively decide whether the patient needed to be monitored on a constant supervision, hourly, daily or weekly basis. The patient would be included in this decision.

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;*** Patients were usually sent to B Wing for their first night. This was the induction wing. They would then be placed on the normal wing the following day. All patients had open access to healthcare. They could come in throughout the day or inform an officer during the night that they required assistance and the officer would alert healthcare.

p) ***What provision was there for individuals to healthcare staff to follow up following their first night in detention?*** A GP appointment was arranged for all patients to attend the following day. The appointment was not mandatory but it was booked for all patients.

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 the standard process.

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);

The healthcare unit is in the centre on first floor right in the middle between all the wings. We have a pharmacy room, two clinic rooms for nurses and doctors triaging and a manager's office. At the very beginning the manager's office was used as a mental health room. This has changed and now the manager and the administration team sit in the office.

Downstairs in the reception corridor we have two healthcare rooms which are used for admissions, when the patient is seen by a nurse or healthcare assistant who does an initial health screening. Those rooms are also used for the optician and dentist as well. Pre Covid the dentist came every 2 weeks, and the optician once a month.

b) Mental health services.

Down the hall from the main healthcare unit patients are escorted by an officer to the mental health room. The mental health team have one office and they also go around the wings and see patients one to one. They book out the visits hall to do group therapies and coffee and chat meetings.

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

Yes they did. If we couldn't cater for patients health care needs we would inform the Home Office by completing a Part C, which is a Home Office form that anyone can use to alert the Home Office to a change in a patient's status so if they are not fit for detention due to a physical problem we would complete that form and send it to the Home Office. We don't offer social care services so the Home Office have to find an alternative place for that person.

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

Yes, we had ECG machines to check heart rate, and all mandatory observations for example oxygen saturation, blood sugar levels.

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

A couple of times we had patients we couldn't look after as we didn't have the facilities for physical disabilities.

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

Not that I was aware of. If equipment was reported as faulty we would replace it and we have a company who come in yearly to check the medical equipment.

62. What if anything, could be improved?

More facilities to cater for people with disabilities and more rooms and training for staff to be able to deal with patients would be beneficial.

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***; We provided dentist, optician services. We can also take bloods, and test urine for substances or infections. We have a smoking cessation service, medication from the pharmacy, a GP on site, and substance misuse services. Anything more specialised is provided externally.

ii) ***Mental health services***; We have a psychiatrist every week, we provide talking therapies, and we have a RMN on duty every day. We now also have a senior RMN post, which we are recruiting to fill.

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

i) ***Nurse;*** patients are seen by a nurse or HCA within two hours of arrival at the centre, Rule 34 provides that they have to be seen by a Doctor within 24 hours of arrival so an appointment is booked for them automatically but they can opt out so there is quite a high drop out rate if the person doesn't have any health issues. After that if someone wants to see a nurse there is a daily walk in clinic 9.30-11.30, when they can see a nurse who will refer them on to other services if needed.

ii) ***GP;*** This is by appointment only and is accessed by attending the walk in triage clinic in the morning to see a nurse first who will then arrange a doctors appointment.

iii) ***Mental health nurse***; the patient is seen by a nurse in triage then referred to a RMN. The RMN makes an appointment and contact patient. They can also be referred by wing staff but might see RGN first as the wing staff are not medically trained and the issue might not be suitable for the RMNs.

iv) ***Psychiatrist/psychologist etc?*** If the RMN feels there is a need to see the psychiatrist or patient wants to see psychiatrist and has a need they will be referred to see the psychiatrist and are normally seen that week.

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

In the afternoon we have booked appointments and chronic disease clinics every day covering different issues for example hypertension and diabetes. These sessions were appointment only and we would often have people coming asking to be seen. We would see them if it was urgent, but sometimes we would get people banging on the door because they had overslept and missed the morning triage clinic.

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. We would sometimes get a build up of optician or dental waiting lists so we would ask for extra clinics or longer clinics. If we had an influx of Rule 35 requests we would put in extra clinics or use the GPs time more wisely. We have to work with what we have got.

67. What, if anything, could be improved?

Access to the mental health room could be improved so that the patient can access it without an officer escorting them. This can cause delays if the wing staff are too busy or short staffed.

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.

It is very difficult to remember what the health problems were in 2017. I think that Rule 35 torture issues were quite significant, food and fluid refusals were prevalent and the dental list was always quite big. I think there were a couple of patients who had to be transferred under section 48 to a more suitable environment.

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

It was hard for staff and patients as they don't know how long they are going to be at the centre for. We can do referrals to hospital but patients got annoyed at having to wait on the normal waiting list. Home Office and legal issues caused a lot of stress and anxiety. Because of that there is only so much an RMN can do as the person did not have a mental health issue the problem was to do with their situation.

Interpreters

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

At the time we used Big Word. We now use Language Line. I have experienced this being intermittent and sometimes there is a delay in getting an interpreter time. The Home Office provide this service, so we alerted the Home Office of any challenges. It is a lot better now with change of provider.

71. Were interpreters readily available when needed?

Not always. This wasn't a daily problem but did crop up regularly.

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

If was a language not readily available it was difficult to get an interpreter and sometimes difficult to get that answer from the patient in the beginning.

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

If we weren't able to get an interpreter we couldn't do the Rule 35 for torture assessment as we need to have an interpreter, so this would have to be delayed until we could get someone.

Supported Living Plan

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

This was to support any patient who needs support in any daily activities.

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

If they have a disability, sometimes it was help with little things like needing assistance getting a tray from the canteen and the person only has one arm so needs someone to carry it to the table for him; or someone with a hearing aid where a personal emergency evacuation plan might be needed; if someone has epilepsy and there is a risk of seizure they would have a SLP so staff would know what to do. They can also be for short term issues, for example if someone is on crutches.

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

Whoever sees the patient first and identifies a support need (wing staff, the Home Office or healthcare) should open up the SLP and then we can have a multi disciplinary team of everyone who needs to know what is involved to support the patients, especially the officers as they spend most time with them.

Complaints

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

Residents can complete a Home Office complaint form or a healthcare complaints form and put them in the confidential boxes on the wing. If they go through the Home Office then it gets disseminated to us and we'll let them know we've investigated and whether the complaint was

upheld or not. They can also make a complaint verbally and we will look into it. I think the Home Office form is provided in different languages.

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 did deal with a complaint at Tinsley House, but I don't remember dealing with any at Brook House, that would have been completed by the Head of Healthcare, Clinical lead or Practice Manger. We have a log where all complaints are recorded and we respond within a timely manner. All complaints are investigated. If the complaint relates to clinical matters then it would be investigated by the clinical lead or a senior nurse and then given to Sandra so she can see if there are any learning lessons, which would be shared in staff meetings. Any non-clinical complaints would be investigated by the Practice Manager, so Michael Wells would have dealt with the Brook House complaints.

I have not had any complaints made against me or member of staff that I can remember.

E Wing

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

E-Wing was mainly for patients who were vulnerable or who were suffering from mental health issues. E-Wing also contained detainees who had infectious diseases or who had not been compliant with the rules. Vulnerable detainees were separated from those who were on E-Wing because they had abused their rights.

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

Officers had more contact with patients on E-Wing and could look after them better. There was only usually around 15 detainees on E-Wing, so it was a lot smaller.

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

Healthcare staff and the GP would attend E-Wing on a daily basis to check in on patients and provide treatment and support.

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 patient was violent or disruptive then they would be moved to CSU. If we were concerned about a patient, we would alert the Home Office and then they would move the patient to CSU with security.

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

Healthcare staff and the GP would attend CSU every day and check in on the patients.

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.

All patients are in possession medication assessed on arrival. We look at their ability to understand the dosage, how to take the medication properly and if we were worried they might overdose or not take enough they would not be given the medication to keep in their possession. As long as we can evidence that we have explained it and that the patient has understood and has no history of non-compliance they would be considered for in possession medication.

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

The patient would come up to healthcare up to 4 times a day to collect their medication. We have set times for doing this, morning, lunch and night time and some patients receive their medication out of hours if there is a need. We arrange that with that person. If they don't come to collect their medication and it is an urgent drug then we are alerted and staff will chase them.

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

I am not really involved in the medication provision. I know we've had patients who didn't always say if they were running low on medication and if it was an urgent drug we could go to Boots at the airport and get it. Also if the patient came in overnight we would call the on call doctor for sign off for the prescription as they can access the medical records (system one) at home.

87. What, if anything, could be improved?

We' are going to get a new system which will allow the medication information and medical history to come straight from hospital and GP to us, if the person consents to this, which will give us an overview of the whole picture we get to support their care. I think this new system is called ICE.

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.

Every patient is health screened on arrival with mandatory questions. One of the questions is in relation to drug and alcohol intake. If the patient informs us that they have a drug or alcohol dependency then they are referred to the GP and substance misuse team for further support.

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

The GP could prescribe medication to help with the patient's withdrawal from using substances. The patient could also be placed on a detox or be placed on E-Wing for constant supervision.

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

The Forward team offered substance misuse support. They provided one to one and group sessions with patients in order to help them overcome their addictions.

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

I think the services and treatment available were adequate. They are better now but they were still adequate at the time of the Relevant Period and I did not know any better.

92. What, if anything, could be improved?

The officers that oversaw E-wing and CSU I do not think they were trained very well at the time in relation to self-harm and mental health. They have received more training now but at the time of the Relevant Period, they probably did not know how to deal with patients suffering from these conditions.

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

There was an outbreak of Spice in the centre around the time of the Relevant Period. It was very hard to deal with, as each batch caused a different reaction to the patients. There were a lot of first responses and emergency call outs.

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

Healthcare would assess the patients and monitor them regularly. We would try and provide as much help as possible but we would occasionally call an ambulance and sometimes have to send the patients to hospital.

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

I did not have any 1-1 contact. I was not a member of the clinical team. I would go to support the staff.

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 see anything that caused me concerns.

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

Not applicable, as I did not have any concerns.

Mental Health

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

I know the patients were cared for to the best of the mental health team's abilities. There was always a RMN on day shift 7 days a week and if a person needed more support they would alert the clinical lead, doctor or psychiatrist so they could have a complex care team meeting if they were concerned. They provided good support.

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

Not that I'm aware of. I thought all of the staff were caring.

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

I don't remember seeing any detention staff doing anything I would question. I know they were not trained about mental health or healthcare, but they do now get mental health first aid training so they know what to look out for.

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

I didn't have any concerns to raise. I would raise any concerns with Sandra and would feel comfortable saying to Sandra I have these concerns and I am raising them with the wing staff manager and copy her into the email.

Rule 35 reports

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

I didn't write Rule 35 reports, they can only be done by a doctor.

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

There are three reasons why a Rule 35 report could be used. If a patient was deteriorating due to detention, torture or self-harm ideations. The Doctor gives guidance to the Home Office and the Home Office caseworker determines what happens from there.

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

The person is seen by the GP with or without Language Line. They might complete a body map if the person has scars or anything they want to claim in support of their Rule 35 report. They can also have a chaperone with them.

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

The Home Office decides this.

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?

There is a standardised report for the GP to complete on System one. The same questions are used each time. The assessment is done face to face and uses an interpreter if necessary. The patient signs the report to confirm what is written is true and it is then sent to the Home Office.

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?

Healthcare has a responsibility as does the Home Office. We do audits to make sure if a Rule 35 report has been sent off that we get the result and we chase if we don't get it.

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

I know from the GP that without an interpreter they couldn't continue with a Rule 35 appointment as they couldn't do in depth assessment so this would delay it. Sometimes we had a lot patients who would need a Rule 35 appointment. We only have a few every day so we have to prioritise the GP's workload to fit that in and do extra Rule 35 clinics. Appointments can vary in length, we usually allow 30-45 minutes.

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

My only concern was when the Home Office wanted to know that the quality of the Rule 35 reports was good. Sandra dealt with this and fed back to the Home Office that we were happy to do this but that we need an audit or some criteria to follow. We also needed more training for Rule 35 as this is very hard to get. Both of these issues have been addressed by Sandra via the Home Office.

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

Sandra raised the concerns I have detailed at 110.

112. What, if anything could be improved?

An improvement would be to always have an interpreter and more training and refresher training on Rule 35. Everyone needs Rule 35 training to have an awareness, but the GP should have extra training on how to complete the form, what is needed and the quality of the information that they are to provide.

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 didn't have much of a role in relation to ACDTs. The nurses would attend ACDT review meetings with Home Office staff.

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

Patients can be identified as being at risk of self-harm or suicide at any stage of their stay. They can either tell us themselves or we could be called to a response. If it is picked up at any point, the patient would be placed immediately on an ACDT.

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

Occasionally we would play a major role, as we would open the ACDT. We carried out observations on the patient and made a note in the patient's ACDT booklet. We provided support and ensured the patient was receiving the medical treatment needed.

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

Healthcare attended reviews and conducted regular welfare checks with the patients.

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, as I did not have any concerns.

ACDT

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

The purpose of an ACDT document is to protect the patient from harming himself or others.

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

An ACDT would be opened any time a patient advised that he was thinking of self-harming or if he already had.

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

ACDT documents were only supposed to be opened for patients who were at risk of self-harm.

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

We would call the Oscar manager and inform him why the ACDT was being opened. We would explain to the patient what an ACDT was and how it could help. It would then be decided between the officers, Home Office and healthcare how often the supervision should take place to ensure the patient is supported appropriately.

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

This depends on the severity of the patient's condition. In very severe cases they would be under constant supervision and have an officer with them the whole time. In other cases it could just be a check in every hour or twice a day. Healthcare would see the patient every day to complete a welfare check.

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

The patient would be reviewed daily. An MDT meeting would be held and a doctor would also see the patient. Everything would be documented in the ACDT booklet.

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

An ACDT would be closed if we were no longer concerned that the patient was at risk of self-harm. The patient had to be part of this process.

127. How could an ACDT be challenged?

If healthcare was not happy with the supervision a patient was receiving and they believed that the patient required more, this could be raised with an Oscar manager or Home Office.

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

Healthcare assessed the patients every day, completed welfare checks and documented this within their booklets.

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

I do not think there were any problems with the process of managing individuals on ACDT documents.

130. What, if anything, could be improved?

I do not think there were any improvements to be made at the time but now with more training the staff are better equipped to support these patients on the wings.

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 did not attend MDT meetings. Any patients with complex health issues would be discussed at these meetings. The management of the patient and next steps would be discussed and agreed on.

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?

Healthcare did attend safer community meetings and AAR meetings. Any concerns raised by patient would be discussed and investigated.

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?

Patient could seek support from healthcare at any time. If they needed to talk to a RMN or a psychiatrist, they could do so.

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?

Healthcare would be informed by the officers that a patient had missed three consecutive meals and we would go to see the detainee and try and find out why they were refusing to eat and encourage them to resume eating. We would carry out physical observations and take their weight and blood sugar levels.

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

Healthcare would see the patient every day to monitor their condition. If a patient had been refusing food or fluids for seven days then we would ask the doctor to see the patient and make sure the patient has capacity. If we were concerned about a patient we would get them assessed by a doctor before the 7 days.

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

Healthcare had to complete specific food and fluid forms. These were sent to the Home Office and G4S.

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

I have never had personal experience of individuals refusing food or fluids.

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 did not have any concerns.

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 attend uses of force to ensure that force is not being used inappropriately and to ensure that the patient is not in pain.

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

Force would only be used as a last resort, if the patient is hurting himself or others.

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

Form F213 must be completed by healthcare staff following a use of force against an individual.

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

Patients would be checked immediately after the use of force incident as long as it was safe to do so and the following day to see if they had sustained any injuries.

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 do not think I was involved I any use of force during the relevant period.

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 uses of force but not around or after this time period. I have never had to intervene and stop a use of force, they were always carried out professionally. I would document in the F213 and patients record.

144. 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 did not have any concerns.

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.

145. 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 was here when he worked here but I don't remember his face or speaking to him.

146. 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.

No.

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

The impact of the Panorama programme was very negative. All staff including myself were shocked. We didn't realise that kind of behaviour was going on in the wings and we felt terrible as we work here and healthcare should be looking after the patients. I just didn't realise it was happening.

148. 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 can't comment on this. I didn't work closely with the Brook House patients. I can imagine it was a hard experience for them.

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

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

I wasn't involved in any age disputes. If anyone has concerns that someone is underage they should report it immediately to the Home Office. The person would be moved to a safe location until it was investigated I believe the Home Office get social services involved.

151. 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.

Yes there have been changes and they have been effective. From Panorama, officers knew someone was underage but assumed that someone had reported it. It seems to be stricter now. There are more audits checking that any issues don't happen again.

Specific Individuals

152. 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*** – He was a security Oscar 1. I might have had a call with him in the day for example if an officer should be in healthcare, but I wouldn't really have any more contact than that. I didn't really know him but he was a bit of a joker. I never saw anything negative like the behaviour seen on Panorama.

b. ***Steve Webb*** – I know the name but I can't remember this person.

c. ***Chris Donnelly*** – Chris still works here. I think he was an Oscar 1 at the time so I might have had a conversation with him in the day if there was an issue for example if we needed an escort to take someone out of the centre. He seemed like a nice bloke.

d. ***Kalvin Sanders*** – I remember him, he was an officer on the wing. I would only have a couple of conversations with him. I recall he was quite a joker as well but didn't think he had a bad bone in his body until I saw him on the Panorama footage.

e. ***Derek Murphy*** – he was one of the managers. I would have spoken to him if I needed an officer. He seemed really nice and I was shocked when saw the Panorama footage.

f. ***John Connolly*** – John was also one of the managers and I might have spoken to him if I needed an officer during the day. I didn't have any concerns about him.

g. ***Dave Webb*** – I recall the name but I don't remember this person.

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

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

j. ***Aaron Stokes*** – I remember the name but i don't recall having any contact with this person.

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

l. ***Slim Bassoud*** – I remember Slim but I didn't have any contact with him.

m. ***Sean Sayers*** – I know the name but I can't remember this person.

n. ***Ryan Bromley*** – I know the name but I didn't work with this person.

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

p. ***Yan Paschali*** – I remember this person, I believe he was one of the officers. I didn't have any contact with him that i remember so i don't know if he was good or not.

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 was quite close to Jo. She was a nurse and was then promoted to senior nurse, then clinical lead for Tinsley house in April 2017. I worked closely with her and I thought she was lovely. I was shocked to see her behaviour on Panorama. I had always thought she was very caring. Whenever I saw her with a patient or staff she was always caring and there to listen.

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.

153. 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 have covered everything within my statement.

Any other Concerns

154. 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 everything within my statement.

155. 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.

Everyone employed during the Relevant Period.

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

Not applicable, as I have covered everything within 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: 04/11/21

Name: Jacintha Dix