Nursing & Midwifery Council

and

BUSS, Joanne

Case ref 063295/2017

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THE NURSING AND MIDWIFERY COUNCIL

V

Joanne Maria Buss

Case ref: 063295/2017

WITNESS STATEMENT OF CALLUM TULLEY

I, Callum Tulley will say as follows:

1. I make this statement in connection with proceedings being brought before a Committee of the Nursing and Midwifery Council (NMC) in relation to Joanne Maria Buss.

2. Since 19 August 2019, I have been employed by the British Broadcasting Corporation (BBC) as a Broadcast Journalist, working on the "Victoria Derbyshire Show". Prior to this, I spent one year on the Journalism Trainee Scheme based with BBC Scotland.

3. Between 6 March 2017 and 19 September 2017, I was employed by the BBC as a specialist researcher working for Panorama, assisting with Panorama's investigation into the Brook House Immigration Removal Centre (Brook House). During my time working for Panorama I was trained in, and subsequently undertook, secret filming and undercover reporting at Brook House. The product of some of that reporting and filming went on to be included in a BBC Panorama programme broadcast on 4 September 2017 (Panorama: Britain's Immigration Secrets). I understand that the BBC has provided the NMC with a copy of the programme.

Signed: Signature **Dated:** 27/08/2019

BACKGROUND TO PANORAMA INVESTIGATION

4. From 26 January 2015 to 7 July 2017, I was employed by the multinational security company G4S, working at Brook House Immigration Removal Centre (Brook House). As above, from 6 March 2017 until 19 September 2017, I was also employed by the BBC.

5. I started working for G4S on 26 January 2015, initially as an Assistant Custody Officer. Following completion of further training by G4S, I was promoted to the post of Detainee Custody Officer (DCO) in June 2015. I was based at Brook House throughout my employment with G4S apart from a period in March and April of 2016, where I was posted in Tinsley House IRC because of an outbreak of chicken pox **Sensitive/Irrelevant** in Brook House.

6. During my time working for G4S, I became concerned about the conditions in Brook House, and the attitudes and behaviour of some staff members there towards detainees.

7. On 11 January 2016 I watched a BBC Panorama Programme called 'Panorama: Teenage Prison Abuse Exposed' which was broadcast on BBC One. The programme showed events in the Medway Secure Training Centre (Medway), in Rochester, Kent and highlighted abuse and mistreatment of young offenders by staff. I learned from the programme that Medway was also run by G4S. At that point, I was already concerned about the conditions for detainees in Brook House, and some of the behaviour of some G4S staff I had seen there, which was echoed in the Medway Panorama programme. I was motivated to contact the BBC Panorama team in the hope that one day there might be a similar investigation into Brook House, if I told them what I had experienced and seen working there.

Signed: **Signature** **Dated:** 27/08/2019

JANUARY 2016 – MARCH 2017

8. On 12 January 2016, I sent an email to the BBC Panorama contact email address explaining that I was a DCO at Brook House. I also gave Panorama my contact details. A couple of weeks later, I was contacted by a member of the Panorama team. For the next fourteen (14) months, although I was in contact with the Panorama team, I continued to work solely for G4S. I did not commence work for the BBC until March 2017, as described later in this Statement.

9. When I was first contacted by the BBC Panorama team, we talked about my experiences, up to my contacting Panorama, of Brook House, including the treatment of detainees and attitudes of some G4S staff. I stayed in intermittent contact with the team over the following months, by telephone. During this time, I continued to observe events and behaviour at Brook House, which I would relay to the team when we spoke.

10. From April 2016, BBC Panorama Producer Joe Plomin was my primary point of contact at the BBC. Joe asked me to make daily diary entries of events at Brook House, based on my observations, which I would be able to share with the BBC Panorama team. I had regular debrief discussions with Joe from April 2016 to February 2017. Throughout our discussions it was clear that the BBC had not made a decision in advance about whether to investigate Brook House, but was keen to be informed about what I was witnessing there. I was always ready to make complaints to appropriate authorities if I was aware or concerned that any incident was going to transpire which posed an immediate risk to life or limb.

11. We discussed the possibility that I might train and work for the BBC as an undercover operative, assisting the Panorama team in an investigation into Brook House during this period. I spoke to a number of previous undercover operatives to discuss their experiences of working undercover. However, it wasn't until February 2017 that Joe Plomin told me that Panorama wanted to

go ahead with the investigation into Brook House, including undercover reporting, and asked me if I wished to be the undercover operative. I did, and I agreed to start working for the BBC in March 2017.

TRAINING

12. On 6 March 2017, I began my employment at the BBC, working under the supervision of Producer Joe Plomin. Between 6 March 2017 and 23 April 2017, I completed a period of training at the BBC, directed by Joe, to prepare me for the period of secret filming. My training comprised mandatory online training, as well as further training over five weeks which was focused on preparing me for the period of undercover reporting I was to undertake at Brook House, and ensuring I was equipped with the necessary specialist knowledge and skills to do so.

13. I was issued with a BBC laptop for this training period and I completed the BBC online training courses, provided by the BBC Academy, which were mandatory for all BBC Panorama employees. These online courses included media law and data protection training, UK anti-bribery training, as well as online production safety and BBC editorial standards courses.

14. Following completion of my mandatory online training, I was given specialist training over the course of five weeks which was focused on camera work and filming; and training on undercover reporting and associated techniques.

15. I watched an introductory DVD training film provided by the Panorama team, providing an overview of conducting investigations of this nature, as well as previous Panorama undercover investigations. After that, I had a number of detailed sessions with Joe Plomin, the production team and external experts covering all aspects of how to operate as an undercover reporter. My training included sessions on wearing and operating secret cameras and microphones; and guidelines and techniques for undercover operatives, including instruction and role play exercises focused on reporting techniques. I also received

training from outside experts including on secret filming and training to ensure filming did not affect safety of detainees, other officers or myself.

INCIDENT ON 25 APRIL 2017

16. I have been asked by the NMC to provide evidence about an incident that I witnessed on 25 April 2017 which Jo Buss attended.

17. Before 25 April 2017 I knew Jo as a colleague but I didn't know her very well. I think I had spoken to her on a handful of occasions in the 2 and a half years that I had spent at Brook House. My impression of Jo from this contact was that she was quite cold with me, the detainees and those detention officers who were more sympathetic towards the detainees. However, I had no reason to think that she would be involved in any abuse or cover up of abuse towards a detainee. I had never known Jo in a social capacity.

18. On 25 April 2017 I worked on E wing, the segregation unit. I was providing constant supervision to a detainee in Sensitive/Irrelevant a constant supervision cell. I will refer to this detainee as "Detainee B". Although Detainee B was under constant supervision, he was not restricted to stay in this room and so was free to walk around the wing as long as I stayed with him.

19. At around 07:30 that evening, I was sitting with my back to the wall at the end of the wing, with room Sensitive/Irrelevant to my immediate left. I heard banging coming from Sensitive/Irrelevant the only other constant supervision cell on E wing, to my far right. The detainee in Sensitive/Irrelevant will be referred to as "Detainee A" in this statement. Detainee A was being monitored by my colleague, Colleague A.

20. Detainee B, who I was monitoring, made his way down the wing and so I also went towards the other end of the wing. I heard the banging from Sensitive/Irrelevant getting louder, so I assumed that Detainee A was self-harming and I thought that Colleague A might need some help. I handed over care for Detainee B to my colleague, Colleague B. She agreed to cover for me. I gave her my Assessment Care in Detention and Teamwork (ACDT) form and she took over for me. I then went to check Detainee A in Sensitive/Irrelevant

21. I walked into the room. Colleague A was already in the room and Colleague C, a Detainee Custody Manager ("DCM"), was either already in the room or arrived at the same time as me. Detainee A was lying in his cell with his head by the toilet basin and his body sticking out into the rest of the cell. When I entered the room, I could hear that Detainee A was attempting to self-strangulate. Colleague C pulled the Detainee away from the toilet basin to stop him self-harming.

22. As Detainee A was self-strangulating, we shouted to get help. I stepped outside the cell to shout to Colleague B to get some officers to help. As I went back into the room, I saw Colleague C removing the ligature from Detainee A. Colleague C used some force to stop Detainee A from strangling himself but no restraints were used at this point. I believe that Colleague D and Jo Buss arrived in the room at around that time, having also responded to the request for help.

23. Detainee A then went into a rage and he made lots of comments about how he was treated. As part of the rage that Detainee A went into, he put a phone battery in his mouth and attempted to swallow it. Staff tried to convince him to get it out but he nearly choked on it. Throughout this period of time when Detainee A was trying to swallow the battery, I was sat on the bed opposite him.

24. When Detainee A was trying to swallow the battery, the staff members I remember being present in the room were Colleague C, Colleague A and Jo.

25. Colleague E, a DCM arrived. Colleague E made derogatory remarks about Detainee A at this point, including referring to him as a *"Duracell bunny"*.

26. Colleague C and I left the room and for a while afterwards various staff members, including Jo, remained around the doorway monitoring the detainee. At one point Colleague E again referred to Detainee A as a *"Duracell bunny"* which is the footage that can be seen in the broadcast programme.

27. A short while later, I think the cell door to Sensitive/Irrelevant was shut. I made my way to Colleague B who was responsible for monitoring Detainee B. I offered to take

back responsibility for monitoring Detainee B, but we agreed that she should continue to observe him for the moment. Within a few minutes I overheard noise again from Sensitive/Irrelevant so I made my way back to Sensitive/Irrelevant. Other staff also began returning to attend to Detainee A.

28. When I arrived at Sensitive/Irrelevant, Jo was already there, standing outside the cell with some other colleagues.

29. I asked Jo what his problem was (referring to Detainee A) and she said "*he's an arse, basically*". I didn't think this was an appropriate way to refer to a detainee.

30. After a few minutes I went into the cell and the staff present were Colleague E, Jo and me. Colleague A may also have been present. Detainee A was back laying on the floor with his head by the bottom of the toilet basin. He was not self-strangulating at this point. In front of Jo and I, Colleague E carried on making fun of Detainee A, saying: *"If he wants to suck on a battery he can suck on a battery"* and, *"If he wants to use it as his dummy, fine. I'm happy with that."* Jo did not object to the comments being made.

31. Colleague E soon left and Jo left too. Colleague E asked me to stay in the cell to keep an eye on Detainee A. Colleague E then left and Jo left too, leaving me and Colleague A in the cell.

32. Detainee A started heaving and gasping for breath as he tried to strangle himself again. I started asking Detainee A to stop and tried to pull his hands away from his throat, whilst also calling for help. We pulled the detainee from the toilet area of the cell and into the centre of the cell. Detainee A was on the floor on his back with his head two metres inside the cell door and the soles of his feet facing the cell window opposite the cell door. I was holding his left arm. Colleague D, who must have arrived in the cell by then, was holding Detainee A's right arm, Colleague A was holding both of Detainee A's legs. Jo was not in the cell at this point.

33. Detainee A soon stopped resisting. Colleague F came back into the cell and I think Jo was just behind him.

34. Colleague F quickly joined in the restraint. We had been restraining Detainee A using an approved technique, but the way that Colleague F restrained him was inappropriate and not advised. He was controlling Detainee A's head by kneeling down with his knees either side of Detainee A's head. He placed his hands on Detainee A's throat with his thumbs on Detainee A's Adam's apple and his fingers around the back of Detainee A's neck.

35. During the restraint, Jo was at the doorway (though I cannot remember whether she was just inside or outside the door). But, because Colleague F was kneeling by Detainee A's head with his back towards the cell door and had his body arched over Detainee A, I cannot say exactly what Jo was able to see. I had a clear view of the door at this point and can confirm that Jo was definitely present and would have been able to see that there was a restraint for Detainee A, but I cannot say for certain that she saw the specific hold that Colleague F had around Detainee A's neck. The restraint has been captured on the BBC Panorama footage.

36. At first, Colleague F had this hold around Detainee A's neck without applying any force. However, Detainee A then became much more agitated, at which point Colleague F exerted a high amount of pressure onto his neck, in particular pressing on the detainee's throat and Adam's apple with his thumbs. It was very shocking to see. As part of an appropriate and approved restraint method, it is right that we control the head as well as the limbs but Colleague F used a totally inappropriate method to do this. When he exerted extreme pressure on the neck it was distressing to watch.

37. When Colleague F started to exert pressure on Detainee A's throat, Detainee A started gasping for breath. I have already said, because of where she was standing, I cannot be certain that Jo could see how Colleague F was holding Detainee A's neck or that she could see the pressure placed on his Adam's Apple. However, she must have been able to hear him gasping for air whilst trying to breathe. It was very clear from the sound from Detainee A that he was struggling to breathe and at no point was there any effort from Jo to get involved, check Detainee A's welfare or intervene.

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38. During the hold, Colleague F also made abusive comments to Detainee A as he said words to the effect of: "*don't move you piece of shit, I'm going to put you to sleep.*" This was whilst Colleague F was applying pressure to Detainee A's throat.

39. The comments were loud enough to be picked up on the footage that I secretly-recorded, but it is impossible for me to be certain if Jo heard them.

40. As Colleague F was strangling Detainee A, his eyes bulged and he appeared to be choking on the saliva coming from his mouth.

41. Although this incident felt like a long time, I think the initial hold around the neck was probably for around 30 seconds and the pressure applied by Colleague F to Detainee A around the Adam's apple was probably for around five or six seconds in real time. Detainee A fell silent and I said to Colleague F "*easy, easy*". Colleague F released pressure from Detainee A's neck. Detainee A started heaving and trying to get his breath back. He couldn't really communicate at that point as he was just trying to get his breath back.

42. After this, we put Detainee A in the recovery position. I think Colleague A left the cell. Colleague F left Detainee A's head and instead took control of one of his arms, I went to control his legs and Colleague D was between us.

43. Once we put Detainee A in the recovery position, he began to cry hysterically and was generally very noisy. I believe Jo stepped out of the cell for a moment to get some medical equipment but I think she returned fairly quickly. Detainee A continued making a lot of noise for several minutes, after which Yan indicated that I should leave the cell. All the staff, including Jo, left the cell at that point.

44. A lot had happened in that previous 30 minutes or so, so I went to the toilet to compose myself.

45. When I returned from the toilet I went to the wing office and spoke to Colleague F. As part of that conversation, he said to me "*we won't record this as a use of force report, as it stands*" or words to that effect. A Use of Force Report is a document that every officer involved in the restraint is obliged to complete when

there has been a use of force. Every officer is obliged to document their involvement in that use of force in the report. My understanding is that if a nurse is present during a use of force, the nurse writes about the welfare of the detainee in relation to the incident and any medical assistance they provided.

46. As we had all used force on Detainee A, we should all have completed use of force reports, but Colleague F was saying that, as it stood, we wouldn't be doing this

47. Not long after this, Jo came in and asked me "*are they putting it down as a restraint?*" or words to that effect. I repeated what Colleague F had said to me, saying *"[Colleague F] said"* that "*as it stands*" we weren't, but said that she would need to speak to him. Jo didn't really react to this. She didn't express surprise, the question was asked very casually and she didn't seem to care when I let her know that we weren't. I don't know whether she had spoken with Colleague F in advance of talking to me and was therefore just checking that I was on board with the approach. I have no doubt that Jo saw a use of force, even if she did not see Colleague F putting pressure on the detainee's neck. When Colleague F said that we were not going to record the incident as a use of force, he would have needed everyone to agree to this, including Jo. If Jo had referred to a use of force or restraint in her clinical write-up, this could obviously get colleagues in trouble for not disclosing it.

48. Jo briefly read out the notes she had already made. I think Jo made reference to Detainee A self-harming in her record but she didn't mention anything about restraint. She said she couldn't write anymore because of an injury to her hand but then went on to say that she was going to go upstairs and write "*War and Peace*".

49. I didn't have any further conversation with Jo about this incident.

This statement, consisting of **11** pages, is true to the best of my knowledge and belief. I confirm that I am willing to attend a hearing and give evidence before a Committee of the NMC if required to do so.

I understand that the NMC may disclose this statement to third parties as is deemed necessary for the purposes of this investigation.

Signed: Signature **Dated:** 27/08/2019

THE NURSING AND MIDWIFERY COUNCIL

V

Joanne Maria Buss

(Case ref: 063295/2017)

WITNESS STATEMENT OF Sandra Calver

I, Sandra Calver, will say as follows:

1. I make this statement in connection with proceedings being brought before a Committee of the Nursing and Midwifery Council (NMC) in relation to Joanne Maria Buss ("Jo").

2. I am currently employed by Gatwick Immigration Removal Centre ("IRC"), Brook House, Tinsley House & Pre-departure Accommodation ("PDA") and Yarl's Wood IRC (Bedford) as Head of Healthcare IRCs. I have been in this role since April 2016. My responsibilities include management supervision, support and development of others, by developing a climate of trust and openness. Chair and attend meetings with staff and key stakeholders, preparing and presenting appropriate reports. On-call support and advice to the healthcare and senior management teams. Monitor and evaluate management information and key performance indicators to ensure compliance with the strategic direction and drive service delivery. Conduct investigations; clinical and disciplinary. Facilitate the provision of primary health care to detainees ensuring the highest professional service is delivered at all times. Arranging, facilitating clinical audits and measuring the outcomes with action plans. I qualified as a Registered Nurse in 1986.

3. I only know Jo in a professional capacity. I work Monday to Friday 9-5-ish. I've known Jo for many years. I had a reasonable working relationship with her. When

I first started in 2004, only Tinsley House was opened. It is a smaller centre. Jo was the clinical lead and she was my line manager. Jo left to do police custody work in approximately 2011 although remained on the bank to do occasional shifts. When she came back we were manged by G4S Health Services and I was Jo's manager as Head of Healthcare IRCs. Jo came back fulltime as a senior nurse in July 2015 and became clinical lead in Tinsley House in May 2017. In 2017, Tinsley House was shut for refurbishment and all the nurses came to work in Brook House.

4. I've not had concerns about Jo's practise. Sensitive/Irrelevant Sensitive/Irrelevant Jo said she couldn't operate keys because of her Sensitive/Irrelevant We're a secure environment and all doors are locked, so we wanted to make sure Jo was be able to carry out her duties. Tinsley House has lesser and lighter keys, hence Jo was placed to work predominantly there. In Brook House we often have to run to first response, in Tinsley House it doesn't happen as often. I am aware that Jo was receiving various Sensitive/Irrelevant and she was under consultant care for her Sensitive/Irrelevant OH said we didn't need to put anything else in place and she was safe to work.

5. Brook House is an immigration removal centre. We collect detainees from various walks of life, for example from prison, police station, streets and airport. There is no fixed time as to how long a detainee can be retained in the centre. Some detainees are here for undetermined time. Brook House accommodates for up to 448 detainees. Brook House is an all male centre, built to a category B prison status. It is a high security building.

6. I can't remember meeting detainee D1527 As Head of Healthcare IRCs I'm not always on the floor meeting people. D1527 was held on Eden wing. At the time of the incident on 25 April 2017, D1527 was on Rule 40. Rule 40 means removal from association. Anybody who is being difficult in the centre or causing issues, will be placed in a room alone. The Home Office will decide how long they will be remain in Rule 40 for. The detainees still have access to food, drink and exercise, they're seen daily by Healthcare. The detainees are released from Rule 40 on the

permission of Home Office following discussions with Detainee, secure staff and healthcare. I produce a copy of The Detention Centre Rules 2001, Rule 40 definition as **Exhibit SC/1**.

7. Eden wing is a smaller / complex wing used to manage a complex population and for removal from association/temporary confinement. It also has two room suitable for those detainees requiring constant observations. Any detainee requiring to be isolated for medical grounds will be housed in this area. The number of detainees vary day to day. There are 13 rooms and detainees generally don't share rooms.

8. At the time of the incident, Jo was clinical lead for Tinsley House, but she was based in Brook House for reasons explained above. My expectations from Jo were to be a role model for junior staff, support and provide guidance for her colleagues and show by example the quality of care expected.

9. Jo had a status of 'torture expert'. A lot of our detainees claim torture when they come in the centre from their previous countries. Jo had been on a torture awareness course on 18 October 2012. It would be usual for the Home Office to train healthcare workers in torture awareness. At that time, it was really difficult to find torture awareness courses, Home Office had no planned courses so we as a company paid for the course from Freedom of torture. It was a two days course. Jo was sent to the course so she could give guidance to staff on this subject. The course was more about the symptoms that people present with. Jo did a PowerPoint on Rule 35, which is a report we have to give to the Home Office for people who claim torture. I produce a copy of the Agenda for Torture Training as **Exhibit SC/2**. I produce a copy of Jo's PowerPoint presentation slides as **Exhibit SC/3**. The report to the Home Office is always written by a doctor.

10. On 4 September 2017, I was told at 4pm that afternoon that the BBC One's Panorama programme about Brook House will be aired at 9pm. The night of the programme I was on the phone to senior healthcare managers. I was called in early in the morning the next day by the Director of Gatwick IRCs, Ben Saunders. Ben spoke to me and said they were suspending all the officers and he felt Jo needed suspending too. At that point, I spoke to my management team. They

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agreed that Jo needed to be suspended. Jo was working at Tinsley House that morning on 5 September 2017. I phoned and advised her not to go to the handover meeting and wait in her office. I was at Brook House, which is half a mile from Tinsley House. I went down to Tinsley House and told Jo that due to the Panorama programme last night, she would be suspended pending investigation. I walked her off site and took her keys and pass from her. Jo said she hadn't seen the programme and she wasn't going to watch it. She was very calm, she didn't cry. Jo didn't look panicked, she said '*I'm not surprised.*' It was more that she'd heard the officers were suspended so she was expecting it for herself as well.

11. I was not involved in any investigation regarding the incidents. I was told by the NMC that despite every effort made, they were unable to interview my previous manager, Angie Hill, who has left G4S in December 2018, just before Christmas and I was asked if I could provide evidence based on the information and documentation provided by G4S and the BBC Panorama programme.

12. There are two incidents which made up the events in question. First incident which occurred at 19:07hrs on 25 April 2017 whereby detainee **D1527** tried to strangle himself repeatedly and swallow a mobile phone battery. Jo can be heard saying in the BBC Panorama programme "*He's an arse basically*". **D1527** attempted to ligature and had the ligature cut and removed.

13. Second incident which occurred at 20:43hrs on the same day on 25 April 2017. There were 2 restraints of the same detainee, **D1527** The first restraint was recorded. Jo was present for the second physical restraint where an officer in an apparent attempt to render **D1527** unconscious choked him. There was no use of force report made after this restraint.

14. I produce a copy of the BBC Panorama footage in relation to both incidents as **Exhibit SC/4**. The relevant times showing the incidents are between 47:44 minutes and 52:10 minutes. The way the BBC Panorama has been edited shows the two incident intertwined. For the purpose of the NMC telephone interview I've watched the footage on YouTube, dated 27 November 2017. Jo's face is blurred

out in the YouTube footage, but I've known Jo for so many years, I recognise her voice. My commentary of the YouTube footage are as follow.

15. At 47:44 – Callum Tulley is heard saying "*This nurse has also been called in*". He refers to Jo.

16. At 47:51 – I can hear Jo's voice, she clearly says "*He's an arse, basically.*" She refers to D1527

17. In relation to Jo saying to colleagues while in front of D1527 after he had tried to strangle himself and swallowed a mobile phone battery, that "*He is an arse basically*", is not an acceptable comment to make. We are the patients' advocate, we need to treat them with respect.

18. At 48:20 I can hear Jo's murmur but I can't pick out any words.

19. At 52:10 Jo asks "*Are they putting it down as a restraint?*" You can't see Jo in the footage, but it's her voice. Callum then says "*I think as it stands, according to what Yan's just told me, they're just gonna leave it.*" Jo then read out her notes "*T-shirt around his neck, angry and upset, phone batter in his mouth, attempt to self-strangulate in toilet. Continued observations due to demeanour. Yea. That's all I can say, isn't it?*" As mentioned above, we're the patients' advocate. Jo's comments appear to demonstrate collusion with the officers not to fill in full records.

20. The risk of not documenting everything is that we're unable to show what care was given. D1527 could have had unexplained injuries which could be detrimental to his health. I keep telling my staff all the time "*document, document, document.*" By not recording everything, also shows a lack of care. We're there to protect detainees. If Jo gave care or saw something inappropriate, she should have documented it.

21 D1527 room was right at the bottom of Eden wing, the furthest you can go. Anyone who is coming out of his room will have to come up towards the officers' room.

Signed: **Signature** **Dated:** 15/3/19 5

22. I produce a copy of the redacted CCTV footage in relation to the second incident as **Exhibit SC/5**. The second incident shown on the BBC Panorama footage is occurring during the footage shown on the CCTV but from outside of D1527 room. There is no actual time documented on the footage. The recording is for a total of 10.13 mins. The first site of Jo is at 01.00 into the recording when she exits the room. Jo is in the room at the end of the recording. I have tried to look at the real time as in the CCTV timeline but am finding it difficult to place the time against this The only link I can see if Jo comes out of the room and calls for help we recorded this at 01.04 in the CCTV this is recorded as 19.34hrs This will make the start time 19.33hrs finish time 19.43hrs which does not link with either incident! I am unable to link this to the Panorama programme as this is no longer available to view on any sites. I confirm I watched the footage live with the NMC's senior investigator during my telephone witness interview. My commentary of the key movements/actions of the footage are as follow.

23. At 00:10 an officer is coming out of D1527 room. I can't tell who it is due to the footage being redacted. It doesn't look like the officer is in a rush. He goes in the direction of the office for the wing.

24. At 00:33 someone came out and went back to D1527 room, but I can't tell who it was. Officers are in dark uniform same as the nurses.

25. At 00:55 another person goes in D1527 room.

26. At 01:01 Jo comes out of D1527 room and goes back. The CCTV footage doesn't show Jo entering D1527 room.

27. At 01:17 Jo comes out again. There is a green oxygen bag on the floor by the table. There would be an oxygen cylinder in the bag.

28. Anybody who's doing a first response has to take the green oxygen bag, red emergency bag and the yellow cutting bag, which is the first aid bag for self-harmers. I produce a copy of the Emergency Red & Yellow Bags contents list as **Exhibit SC/6**.

29. At 01:48 Jo goes back to D1527 room empty handed.

Signed: Signature **Dated:** 15/3/19

30. At 02:05 Jo moved the oxygen cylinder. It looks as though she's bent down to get the oxygen out.

31. At 02:18 Jo comes out again and moves the green bag. From the other side of the table she gets the red emergency bag.

32. At 02:28 Jo takes the whole red bag in D1527 room.

33. At 02:35 Jo pops her head out and takes something out of the red bag.

34. At 02:55 Jo comes out of D1527 room with something in her hand, which looks like the wire to the BP machine.

35. At 03:05 Jo is rummaging in the red bag.

36. At 03:20 Jo puts the BP machine on the table.

37. At 03:43 officers are locking down the other rooms and putting everybody in their room. If they need to remove a person from one room to another, they would put all the other detainees to their room for security reasons.

38. At 07:07 Jo comes out of D1527 room, but can't see what she actually does.

39. At 08:54 Jo kicks the green bag out of the way and all four officers come out of the room with D1527 still in the room.

40. At 09:45 Jo goes back to D1527 room and the footage ends at 10:13.

41. I produce a copy of the CCTV timeline showing 'real time' hours and minutes on the day of the incident as **Exhibit SC/7**. This document was created as an annex to the investigation report by one of my colleagues.

42. From the CCTV footage we can't see what Jo was doing inside of D1527 room, so it's not possible for me to comment on those events. However, Jo's documentation was extremely poor after the incident. I believe in the Panorama broadcast Jo is heard saying 'she won't record the restraint'. It can be said that Jo made a deliberately incomplete record of this incident, omitting the use of force by officers. I produce a copy of the Guidance Notes for Completion of

Incident Report Forms as **Exhibit SC/8**. The guidance notes are used by everyone.

43. I produce a copy of the Incident Report as **Exhibit SC/9**. This report was completed by Steve Loughton, officer. There is a clear flowchart attached to the report explaining who has to complete which part of the report.

44. After every use of force a report needs to be completed. The only part Healthcare staff completes is the F213, Report of Injury to Detainee. An F213 must be completed on all detainees, even if they appear not to have sustained any injuries. A copy of the F213 must be attached to the use of force report and placed in the use of force incident file. I produce a copy of the F213 as **Exhibit SC/10**. This F213 was signed by another nurse, Mariola Makuka on 25 April 2017. Mariola may have been called down after the incident. Jo was due off at 9:30pm. The F213 definitely should have been written by Jo as she was a witness to the incident.

45. Anybody who has a Planned restraint done on must have a nurse there, any unplanned will have a nurse called. During the control and restraint ("C&R"), the nurses' role is to ensure safety of the detainee. If airway is compromised or the detainee becomes unwell in any matter the nurses have the right to say 'MEDICAL EMERGENCY, TAKE HANDS OFF'. Then the officer must take their hands off of the detainee. Having seen the Panorama footage, I would have expected Jo to have said that to the officer.

46. After C&R, once officers leave, the detainee comes down from the adrenalin rush. Because of the changes to the body in blood pressure, pulse, respiratory rate and oxygen supply dropping people can collapse or become faint. That's why nurses stay behind to observe. That could be why Jo went back to **D1527** room as we could see on the CCTV footage. She didn't take any further equipment in, which would indicate that **D1527** was safe.

47. I produce a copy of an extract of **D1527** patient note as **Exhibit SC/11**. I confirm the entry was made by Jo on SystmOne. The time of entry 18.51 is the time the screen was opened on this patient. The screen was saved for his

documentation at 20.28hrs so this could have been written at any time in-between. I assume Jo was due to write something and then got called to the wing and the screen was still open when she returned to write. Given the second incident didn't happen until 20:43, these notes must relate to the first incident at 19:07. I would say Jo's notes are insufficient. She hasn't put that D1527 airway was obstructed or recorded any observations apart from 'visual obs resps 16'. Jo hasn't put his BP, which I would have expected her to write down. She hasn't put anything about D1527 neck ie full range of movement. Jo's been on various triage training, she's an experienced nurse, she worked in custody, she knew how to do comprehensive notes and she should know how to forensically write notes. I put in every staff meeting about documentation. I tell staff to write in full 'if it's not documented it's not happened'.

48. I produce a copy of the On-going Record sheet as **Exhibit SC/12**. This is the Constant watch record sheet from the Assessment Care in Detention and Teamwork ("ACDT") document. I produce a copy of the ACDT self-harm reduction strategy booklet as **Exhibit SC/13**. Jo wrote at 19.40 which would be after the first incident which took place at 19.07hrs. It is poor that the officers have not recorded the incident. This is not Healthcare's record sheet. It's kept on the wing with the detainee in their room. Although, at 19:40 it doesn't have Jo's name by the entry, I recognise her writing. This entry is sufficient, you wouldn't write medical notes in here. I wouldn't expect Jo to write a lot of information on this sheet.

49. I produce a copy of the Use of Force document as **Exhibit SC/14**. This document was completed by officers. It marked to say that no hand held camcorder or body worn camera was used during the incident. About half way down, it shows that Jo was informed at 19:20 by Steve Loughton. To the question 'Was a member of Healthcare present throughout the incident (Doctor, Registered Nurse or Healthcare) it is marked as 'No'. It is also stated in this form that an F213 or equivalent form was completed by Jo, when it wasn't.

50. I produce a copy of the Monitoring of Patients During and After Restraint Policy as **Exhibit SC/15**. I haven't got any evidence that Jo has read this policy. This

policy was issued in August 2016. Policies are available on Google drive. Staff didn't sign anything at the time to say they have read the policy. Since the incident, there is a more robust process for ensuring staff reads policies. This was one of the learnings.

51. In the policy, under point 4.2 'Monitoring during restraint', it states that bag and mask and airway control devices must be close by, which they were as could be seen on the CCTV footage. Further, it states all observations, visual and physical, must be recorded as soon as practicable, but it wasn't done fully by Jo.

52. Under point 4.2.1 'During de-escalation' it states, that whilst de-escalation is attempted, if possible HCPs should carry out the physical observations normal for a routine examination. Once de-escalation is achieved, a routine examination should be carried out, where the routine observations should be repeated. Recording and advice should then proceed in the routine manner for the particular facility. There is no evidence of post observations by Jo after the event, there is nothing documented anywhere.

53. 4.3 of the policy refers to 'Monitoring after restraint'. In particular, it is stated "*A full routine examination must follow successful de-escalation, recorded in the normal manner.*" Whilst Jo did go back to D1527 room, there no evidence of any recorded observations. Page 26 of the Policy is a clear flowchart. It is an easy to follow policy.

54. I confirm the Use of Force Policy is not a Healthcare document, it only applies to officers.

55. There was no safeguarding referral made following the incidents. D1527 was put on constant watch rather than making a safeguarding referral, which was appropriate for the settings we were in. It would not be usual practice to complete a safeguarding referral for those on a constant watch as they are detained in a place of safety. This constant watch was already open prior to the first incident.

56. Jo has never reported she has any memory issues nor has this been raised in any OH assessments she has had. For the purpose of my interview with the

NMC, I've looked at Jo's OH reports, return to work assessments and sickness absence reports. I've had one to ones with Jo but nothing like this has ever been raised by her.

This statement, consisting of **11** pages, is true to the best of my knowledge and belief. I confirm that I am willing to attend a hearing and give evidence before a Committee of the NMC if required to do so.

I understand that the NMC may disclose this statement to third parties as is deemed necessary.

Signed: **Signature** **Dated:** 15/3/19

THE NURSING AND MIDWIFERY COUNCIL

V

JOANNE MARIA BUSS

(Case ref: 063295/2017)

SUPPLEMENTARY WITNESS STATEMENT OF SANDRA CALVER

I, Sandra Calver, will say as follows:

1. I make this statement in connection with proceedings being brought before a Committee of the Nursing and Midwifery Council (NMC) in relation to Joanne Maria Buss (the registrant).

2. This statement is supplementary to my witness statement signed and dated 15 March 2019 (original statement).

3. At paragraph 14 of my original statement I state that for the purposes of the interview watched the BBC panorama programme on YouTube. For the purposes of my supplementary statement I have been showed a copy of the original BBC Panorama footage that was aired on the BBC and I can confirm that this footage is exactly the same as what I had previously viewed on YouTube.

4. At paragraph 9 of my original statement I refer to the registrant as a torture expert and I have been asked to expand on this. G4S did not offer any official training about torture awareness. The registrant had been on a torture awareness course and the registrant had been asked to share her training with new starters.

Signed: Signature **Dated:** 21/06/19

5. When a new detainee is brought into the Centre, staff ask them if they have suffered from being tortured in the past and if a detainee does declare torture then it is recorded in their clinical notes. If torture is declared then the registrant would speak to the detainee about this to get an idea about where the torture happened, how it happened, any scars the detainee has or lasting effects. The registrant would then pass that information on to the GP's who would assess the detainee's psychological and mental wellbeing. I am not sure if D1527 declared previously being tortured but if he had declared this it would have been recorded in his clinical records.

6. At paragraph 12 of my original statement I refer to an incident where the registrant made an inappropriate comment about D1527 I can confirm that I was not present when this comment was made and the first time I heard about the incident was from watching the BBC Panorama programme.

7. I was shocked by what the registrant said and the way she said it. I was shocked because the registrant has said on numerous occasions that she is concerned about detainees' emotional wellbeing so I did not expect that sort of comment to come from her. From watching the programme, it looks like the registrant made the comment outside of the room, but I am not sure about who else would have been around to hear the comment.

8. At paragraph 20 of my original statement, I stated that if the registrant had given care or seen something inappropriate she should have documented it. I understand that whilst the registrant did not restrain D1527 she witnessed it. This is not made clear by the BBC Panorama programme, but from reviewing the bodycam footage, it is confirmed that the registrant was in the room when the restraint took place.

9. I would have expected the registrant to complete a F213 report following the restraint she witnessed. I have also mentioned the F213 report at paragraph 44 of my original statement. The F213 report is a form that should be completed following an incident by every person involved in that incident. I

would expect the registrant to have written a statement commenting on the safety of the patient during the restraint and the use of any force either planned or unplanned.

10. It would have been the registrant's responsibility to stop the restraint if she felt that there was a medical emergency. Following the broadcast of the programme, it was determined that detainee D1527 had been choked and this would have constitute a medical emergency requiring intervention from the registrant.

11. The registrant recorded limited information in the detainee's clinical notes and got another member of staff to complete the F213 report, when she should have done this herself. She is also heard saying on the BBC Panorama Programme that they were not going to write the incident up, or words to that effect.

12. I have been asked by the NMC to comment on whether I think reasonable restrain t was used. I am not a qualified instructor in restraint however from what I saw on the BBC panorama programme, the restraint was inappropriate as hands were placed on the detainee's neck.

13. I have also been asked by the NMC to comment on how serious I think the registrant's actions were. A key concern was that the registrant failed to record fully what happened and there is a risk that the detainee could at a later stage have claimed injuries or have asserted a version of events that may not have happened.

14. The lack of records means that there is a failure to ensure a full picture of the incident is taken. Further, when a detainee is being deported they are given a copy of their clinical records so if an injury does come to light later it is important that they have the correct information.

15. Had the incident not been captured by the BBC programme, there is a chance that I would never have known that the detainee's safety was being put at risk.

Signed: Signature **Dated:** 21/6/19

3

Another concern was that the registrant would have known that the D1527 safety was being out at risk because I have heard one of the officers saying that the D1527 was being choked and the D1527 also said that he couldn't breathe.

16. The registrant had completed both personal protection training and breakaway training, both of which cover first response. The registrant also would have competed Intermediate Life Support training as all registered nurses complete this.

This statement, consisting of 4 pages, is true to the best of my knowledge and belief. I confirm that I am willing to attend a hearing and give evidence before a Committee of the NMC if required to do so. I understand that the NMC may disclose this statement to third parties as is deemed necessary.

Signed: .. Signature Dated: .....2/6/19..... 4

THE NURSING AND MIDWIFERY COUNCIL

V

Joanne Buss (Case ref: 062525/2017)

WITNESS STATEMENT OF ANTHONY EDWARD HAYES

I, Anthony Edward Hayes, will say as follows:

1. I make this statement in connection with proceedings being brought before a Committee of the Nursing and Midwifery Council (NMC) in relation to Joanne Buss ("the registrant").

2. I am the Head of Security and Operations in Care and Detention services for G4S and I am based in Her Majesty's Prison (HMP) Oakwood and. I have been in this role since April 2012. Part of my role as an Operational Senior Manager is the responsibility for the physical and procedural security of the prison as well as heading the intelligence network and operation. The intelligence network requires working closely with police and other agencies to tackle criminality in the prison.

3. On 24th August before the British Broadcasting Corporation (BBC) aired their Panorama program Undercover: Britain's Immigration Secrets on 4/9/2017 they alerted Peter Neden, Regional G4S President UK and Ireland by letter to matters concerning the treatment of detainees held in IRC Gatwick (Brook House) which they have uncovered during secret filming. Some of the incidents reported were shown in the programme and others did not feature but were listed on Annex A which accompanied the letter to Mr Neden. G4S in turn alerted the Authorities of the concerns that the BBC had discovered.

4. In response to these allegations, Paul Kempster, Chief Operating Officer, G4S's Care and Detention Services, commissioned an investigation to look into the concerns that the BBC Panorama program had identified. A team of 6 staff members (including myself) were directed to Brook House and a number of the allegations were allocated to each team member to investigate. There were in total two allegations made against the practice of the registrant and I investigated them both.

5. The registrant was employed as a Clinical Lead Nurse for G4S. The registrant was employed from 5/10/10 and after these allegations took place has been on suspension. Part of the registrant's role included giving medical assistance after or during incidents were detainee came to harm, following any use of force or other

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injury. The registrant was had an obligation to ensure that national and local reporting procedures were followed.

6. The allegations made against the registrant can be seen in on page 2 of my investigation report, a copy of which I produce as **Exhibit AEH 1** and are also set out below:

   a. On the 25th of April 2017 the registrant said to colleagues while in front of D1527 after he had tried to strangle himself that D1527 who had tried to strangle himself repeatedly and swallow a mobile phone battery, that D1527 was "an arse basically".
   b. On the 25th of April there were two restraints of the same detainee, D1527 D1527 on E Wing. The first was recorded. The registrant was present for the second physical restraint of D1527 where a prison officer, in an apparent attempt to render the D1527 unconscious, choked the detainee. There was no 'use of force' report made after this restraint. The registrant made a deliberately incomplete record of this incident, omitting the use of force by officers.

7. To gather evidence about this incident I had to refer to various documents and footage provided by G4S's CCTV and from the BBC Panorama program.

Allegation 1:

8. The reason that the G4S became aware of this incident was because the BBC had released footage which shows the registrant referring to D1527 as "an arse basically". This language is unacceptable and I would have expected this to have been added to an incident log. However the comment that the registrant made is not recorded anywhere and it is not referred to in **Exhibits AEH2 – AEH6**, which are explained below and which contain the relevant documentation of this incident. What these exhibits are able to demonstrate is that the registrant was in the time and place where the incident occurred however the CCTV footage also clearly shows this.

9. There is an entry made by the registrant in D1527 constant observation paperwork which is exhibited as **Exhibit AEH 2.** The entry made by the registrant is on 25/4/2017 at 19:40 and details the incident in Allegation 1 when D1527 tries to strangle himself. This entry confirms that the registrant was in D1527 room which is where she was purported to have referred to D1527 as "a bit of an arse". The registrant confirms in her interview that the entry was made by her. The notes of this interview can be seen in **Exhibit AEH.3** The G4S CCTV footage also shows the registrant entering D1527 room at that time and the registrant writing in the constant observations log.

10. For this incident a Use of Force Document a DCF2 produced as **Exhibit AEH 4** was completed Steve Loughton. A DCF2 is completed when any force is used on a detainee. This document provides further proof that the registrant was present during the incident as the registrant is listed as the member of health care who was present, although the report does show that the registrant was not present during the entire incident.

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11. A report of Injury to the D1527 (an F213) produced as **Exhibit AEH 5** was completed by the registrant 25/4/2017This shows that for this incident the registrant was following national policy in properly completing this report. The report details the incident in question; including the physical state of D1527 and stating that the registrant treated D1527

12. The incident report is shown in **Exhibit AEH 6.** This is a localised document which records the details of the incident. This report is then uploaded onto the Incident Reporting System (IRS) a system used by all prisons and removal centres. When a significant incident occurs such as a detainee self-harming, sustains an injury or force is used on a detainee it is a mandatory National policy that an incident report is completed and uploaded onto the IRS. This incident which involved a D1527 trying to strangle himself would most definitely be classed as a significant incident. The incident report contains a flow chart for what report is required, guidance notes for completion of incident report forms and a statement from Steve Loughton (SL) who was the prison officer present during the incident. In his statement SL makes no mention of the registrant's use of language which I would have expected. If national policy had been followed then the registrant's behaviour should have been noted as her behaviour was inappropriate and unacceptable and something that should have been made note of.

13. We held an interview on 7/9/2017 with the registrant, the notes from which can be seen in **Exhibit AEH 3.** The interview had had to be rearranged several times owing to the registrant having difficulty in getting a representative. I was joined in the interview by Angie Hill (AH) Director of Nursing at G4S Health Services, who was questioning the registrant from a medical perspective and assessing her clinical practice.

14. I questioned the registrant about allegation 1 and she engaged very poorly and said that she could not remember anything from that day. I stated that she had been on duty and when I provided proof from the documentation in **Exhibit AEH 2** the registrant replied "if you say so" I showed the registrant a copy of the F213 and the registrant acknowledged that it was her writing but said that she could not remember the detail or the incident.

15. When we questioned the registrant about allegation 1 the registrant said that she would not use language like that. When we showed the registrant the BBC panorama footage which showed her calling the D1527 a bit of an arse basically the registrant confirmed that it was her in the footage and acknowledged that she had said those words.

Allegation 2:

16. Having seen the panorama footage of allegation 2 I would have expected there to be the same documentation as there had been for the first incident in allegation 1. I should have been able to find an incident report, a report of Injury to the D1527 and a Use of Force Document, however I was unable to find any documents concerning this incident. There were no documents detailing the incident that would

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disprove that the incident had not happened. If there had not been the BBC Panorama footage I would not have known that this incident had occurred. It is mandatory according to national policy that applies to all prisons and detainee centres that when any incident that involved a detainee being restrained or having to use force this must be reported.

17. During the interview AH asked the registrant to describe her role and responsibilities as well as the process the registrant had to follow when attending an incident? The registrant said that her role was to observe the incident and make sure it was safe to enter. Once she had entered she would to carry out treatment and record notes of any treatment given as well as any interactions and observations. This record would be uploaded onto SystmOne, a clinical support system used in primary UK healthcare. When asked if she had followed this process for this incident the registrant replied she didn't remember as she was unable to remember one incident from the next.

18. I asked the registrant what further action she should have taken and the registrant replied that she should have completed a clinical incident form and a positive intervention form and done an incident report. When I asked her why she had not done these actions the registrant replied she didn't know and that it had been a 13 hour shift. This I did not view as an acceptable excuse for failing to follow appropriate policy.

19. When I asked the registrant if she remembered making notes about this incident and uploaded it onto SystmOne the registrant replied no and then said er I hope so.

20. During the interview I showed the registrant the footage from the panorama clip of the incident, the registrant replied that she could not remember the incident. The registrant while watching the clip was very quiet but remained very matter of fact about not being able to remember and when I pressed her became quite terse. The registrant did comment that the footage of allegation2 did show excessive use of force and said that it was not appropriate and that she would have stopped the prison officer applying this force. I asked her why she had not done so in this situation and the registrant replied that she could not remember. When I pressed the registrant for times and further details she said she didn't remember she said what happens at the centre stays at the centre and that she would then go home and forget about it. This particular comment troubled me.

21. I asked the registrant why she didn't report it and the registrant said that she could not remember. I asked the registrant whether she was aware that by not reporting the registrant would appear to be colluding with the other prison officers the registrant said she didn't know but that she should have done better.

22. I asked the registrant if there had been any similar incidences where excessive use of force was used and the registrant said that she could not remember.

23. During the interview the registrant stated that she was an experienced nurse and used to responding to serious incidences. When asked if she had any medical conditions which would explain her memory loss and inability to recall the detail of

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this incident the registrant stated that she Sensitive/Irrelevant after an incident some years ago which resulted in memory loss.

24. The registrant said she was upset by the way the panorama footage portrayed her.

My Conclusions:

25. From the information that I gathered and assessed it clearly supported both allegations concerning the registrant that were made by the BBC

26. My concerns from this investigation are that a serious incident had occurred where an experienced senior nurse was in a room where excessive use of force was being used against a detainee and she did not intervene. Secondly the registrant failed to follow mandatory national policy which required she report this matter.

27. After the interview the registrant was suspended from practice and G4S. I concluded my report and sent it to Paul Kempster.

This statement, consisting of 5 pages, is true to the best of my knowledge and belief. I confirm that I am willing to attend a hearing and give evidence before a Committee of the NMC if required to do so. I understand that the NMC may disclose this statement to third parties as is deemed necessary.

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