Confidential

Independent Investigation into Brook House

Friday, 27 April 2018

Interview with
Mr Michael Wells
Healthcare Practice Manager, Brook House

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Investigators: **Mr Ed Marsden (Verita)**
Ms Kate Lampard (Verita)

1. **Mr Marsden:** This is an interview with Michael Wells from Healthcare and it is part of the independent investigation at Brook House. It is 27 April 2018. [*Introductions*]

2. Michael, thank you very much. Kate has given you the introduction. I have an easy question to start with, tell us a little about your background and what you do here. I think I know, but it would be really helpful to hear it from you.
3. **A.** I am the Healthcare Practice Manager at Brook House. I have been in post with G4S since February 2014, when I started as an admin assistant. NHS England took over commissioning and I was successful to become practice manager at Brook House. They required two practice managers and two clinical leads. Previous to that, I worked at East Surrey hospital, which is the local hospital, in the medical records department, so I have no real managerial background.

4. **Q.** When you say that there are two practice managers, is there one at Tinsley?
5. **A.** Yes, there is a practice manager at Tinsley House.

6. **Q.** I have a really technical question, and I know you will be able to answer it. What is actually the status of Healthcare in terms of its registration? It is registered with the CQC and, as I understand it, Sandra is the –
7. **A.** Yes, Sandra is the registered CQC manager.

8. **Q.** What is it considered to be?
9. **A.** It is the equivalent of a GP provision. The services we provide are nurse and GP-led, but we also deal with the emergency situations.

10. **Q.** Do detainees go onto a nominal list? Is it like a GP practice in the sense that a detainee comes here and they join –
11. **A.** Yes, immediately, we transfer their care. If they were in the community, we will transfer their care from a community GP to us and then, if they leave us and go back to the community, we would ensure that they take things like their medical record, so that they can go and re-register with their GP. If we are replying to medical records in the community, we often say to them, "We have taken over their care at the present time. Are you able to share with us what you know about the detainee? We have their signed consent, as well as a transfer."

12. **Q.** Just another technical question then - is your funding list dependent? It is not list size dependent?
13. **A.** No, it is not related to QOF or anything like that. It is direct funding from the NHS for the service.

14. **Q.** So essentially, NHS England is putting a slab of money down on the table to G4S?
15. **A.** Yes, to provide the services that they want to see in the centre. That is what we do.

16. **Q.** Yes, and the CQC part of it is that you are inspected?
17. **A.** We are inspected, along with HMIP. We have just had one at Tinsley. It is a joint inspection with HMIP. There is the CQC element and there is a pharmacy element as well.

18. **Q.** To whom do you report?
19. **A.** Myself? I report to the Head of Secure, and that is Kerry George.

20. **Q.** Okay, and so Sandra is – ?
21. **A.** Sandra is the Head of Healthcare. I used to report into Sandra but there have been some structural changes. I then reported into the regional account manager, who is no longer in post, and they have made that a national post, and I no longer report into that post.

22. **Q.** Does Sandra report to Kerry?
23. **A.** Yes.

24. **Q.** Are you on a par with - ?
25. **A.** The clinical and non-clinical structures are slightly different. I would normally let Sandra know what is going on, as well as Kerry, just because of Sandra's role. If a clinical lead was in post as well, and that is a vacancy that we currently have, we would be sitting at the same sort of level.

26. **Q.** You and the clinical lead? That was Chrissie before she left?
27. **A.** Yes.

28. **Q.** On a day-to-day basis, what does Monday to Friday look like? I assume that you wouldn't work weekends?
29. **A.** I don't work weekends, no. I work Monday to Friday. I oversee all the non-clinical aspects of Healthcare. I look at our performance indicators, look at the payroll, staffing, rotas – everything that is non-clinical. I oversee what my admin staff do - I have one admin assistant here and a part-time at Tinsley, that the other practice manager manages.

30. **Q.** You are faced with the prospect of managing the clinical rota?
31. **A.** Yes.

32. **Ms Lampard:** Could I just ask about staffing? By that, do you mean clinical staffing?
33. **A.** Yes, I deal with the rotas, and rota staff as per their contracts. Then, once that is complete, Simon has sight of that, just to double-check the skill mix. I know roughly what skill mix we are looking for and so I wouldn't have, for example, three paramedics on a day shift as medication will be an issue, and so I would always make sure that I have nursing staff on a day shift. We only

have one in post at the moment, but we have two in vetting, so it will work out that we have a paramedic on shift every single day of the week, along with general nurses, mental health nurses, HCAs and a pharmacy technician.

34. **Mr Marsden:** In terms of the daily shift pattern, what is average staffing? What are you aiming for?
35. **A.** The aim is to have three qualified members of staff working on the general side of Healthcare, looking the primary care elements, but only two healthcare assistants to support. That works around admissions, medical responses - it just means that we have no staffing on the floor to support all of the different elements, as well as working with the GP. Then, on the mental health side, at Brook House, we would have a RMN and a senior RMN on duty on a day shift.

36. **Q.** Okay, on the day shift?
37. **A.** The RMNs are shared across –

38. **Ms Lampard:** I am sorry – an RMN and a senior RMN?
39. **A.** A senior RMN, yes, on a day shift. The RMNs in the day are shared between Brook and Tinsley House, so they bounce between the two sites. They tend to do six hours at Brook and three and a half hours at Tinsley.

40. **Q.** Do they both do that?
41. **A.** No. The RMN is a five-day a week cover and so she doesn't work weekends. She sees the core days of the week and manages the caseload, and works closely with a psychiatrist, ensuring that they are on site. There is all the group work –

42. **Q.** What about the senior RMN?
43. **A.** Sorry, that is the senior RMN. The RMN will carry out talking therapies, and carry out group sessions, ACDT reviews, constant supervision reviews, Rule 40 reviews and all that type of thing. It is about just engaging in the centre. The RMN will mainly be doing the one-to-one sessions.

44. **Mr Marsden:** In terms of how you spend your working week, is it mainly based in Healthcare?
45. **A.** Yes.

46. **Q.** It is where I went that day, yes.
47. **A.** Yes, and I am based in Healthcare full time, really.

48. **Q.** Essentially doing a managerial role?
49. **A.** Yes, it is more operational management, really, about the day-to-day running. For instance, if we were short at all, for example through sickness or anything like that, then it would be about how we were going to cover the safety element – through talking with the clinicians, and asking them how they feel we need to work it. I would then put into place where the staff need to go, it is more about operational management and then overseeing the non-clinical bits as well.

50. **Q.** While we are on the subject, can you tell us about the working week provision of Healthcare facilities? What are the main clinics? What are the main focuses?

51. **A.** There is a doctor on site every single day. At Brook House, the doctor is there in the afternoon, and covers Tinsley House in the morning and is in for six hours. In the morning, for the nursing staff, there is a medication round, so we have a CD round first thing, and then we have our general medications.

52. **Q.** Controlled drugs?
53. **A.** Controlled drugs, yes. The controlled drug medication round first for half an hour, and then we have the 45-minute medication round. In that time –

54. **Q.** When you say 'round', does that mean people are actually coming to the –
55. **A.** Yes, they come to the medication hatch and collect their medication. Anyone who is on Eden Wing will have their medication taken to them, due to their access in the centre. Then we will have a blood clinic running, so we will do blood tests in-house, and that will be running alongside that medication time. We have very few people for blood tests, so it is quite easy to manage that caseload through, it is normally the healthcare assistants who take the blood.

56. After that, we have a 15-minute turnaround, so we ensure that our clinics are all set up and ready. Then we have a two-hour nurse triage clinic, there is open access, so any patients can come and access Healthcare. If it is revised guidance, or if they are feeling unwell, with any questions or queries – for anything like that, they can come there and that is where we will triage them. It might be that someone has dental pain, and so we will arrange for them to see the dentist, or perhaps an optician or a doctor. There are onward referrals to mental health, if you have any concerns, there can be a referral across to mental health.

57. **Q.** Would you be able to see everyone during triage? We did a detainees' forum, or we have done a couple of them, and these are their issues not ours. They will say 'I went down, and there were a lot of people at triage.'
58. **A.** Yes, it depends on what is going on in the centre. If there are activities in the centre, we tend to be quieter, with not as many patients for triage. However, if it is a bit chilly outside and a bit damp, a bit wet, we tend to have more people coming through the door. I don't know whether that is because there isn't enough going on in the centre. Sometimes they like to come just to have a chat really, it is quite nice and quite a safe environment for detainees to talk to staff, I feel.

59. **Ms Lampard:** I am sorry, you didn't quite answer the question. Can you usually get through?
60. **A.** Yes, you can normally get through. Very rarely would I say that we over-run.

61. **Q.** Will you over-run, or will you send people away?
62. **A.** If the nurse was concerned, they would see the patient. If the nurse wasn't concerned, they would tell them to "come back tomorrow, or come back this afternoon and we'll see if we can see you." Very rarely would we turn people away, that would be the nurse who turns the patient away. They would often listen to what the detainee had to say, and would ask what was the issue. "Is it an emergency? Can you wait?" If not, they would see them.

63. **Mr Marsden:** In general terms, what do you think Healthcare here does well? What do you think are the sources of frustration to you? You have been here for quite a long time now.

64. **A.** I think the Healthcare provision is good. I think the detainees have a lot of access to different specialties – in fact, they have open access for two hours of the day, to walk in and walk out, whatever they want to do. They have access to different materials and everything else. I feel that the standard of provision is good. Even though they might not feel that it is. I think it is about the level of expectation. For some of the detainees who have come from prison, a lot of the things are in-house, whereas for the IRC it is not, it is a little different. I would say that dental is one area that is lacking, definitely, because we don't have a dental suite and that is often picked up in our general inspections.

65. **Q.** There is a visiting dentist, isn't there?
66. **A.** There is a visiting dentist, yes.

67. **Q.** Is that every two weeks?
68. **A.** Yes, every two to three weeks. She does a very basic triage.

69. **Q.** If you had dental pain, and you were waiting to be seen by the dentist, would you have to manage it?
70. **A.** Yes, we would manage it with pain relief. If there was an abscess or infection, we would look to access the emergency dental services at East Surrey or Crawley hospital. Crawley hospital is open after five o'clock, every day of the week. At East Surrey, we have two specific slots on a Saturday and a Sunday, just for detainees at Brook House, so we can access those at any point.

71. **Ms Lampard:** That is at the local hospital?
72. **A.** Yes, that is East Surrey hospital, which is just down the road.

73. **Mr Marsden:** Your overall feeling is that Healthcare provision fairly good, but for dentists it is a no. What else do you think has a 'rubbing point', or is not so strong?
74. **A.** There is always room to improve. I don't think you should ever say 'This is where we are at, and this is where we are staying'. Healthcare is such a fast-paced environment and there are areas where we can improve. One area was pharmacy provision and so we have introduced the pharmacy technician. That is a new post that we have introduced and that is someone who can talk to patients about their medications, do spot-checking and all that type of thing. That is an addition and we are looking to bring in a pharmacist from our medications supplier at Boots at the airport, hopefully for eight hours a week across the two sites. We can do additional pharmacy clinics where detainees can meet the pharmacist. I think trying to give more of a community feel to Healthcare is one area we can improve.

75. **Q.** When we spoke to Sandra right at the outset of the work, she said that there were quite a lot of vacancies and recruitment had been a challenge. I don't know whether it remains a challenge but what vacancies are you carrying at the moment?
76. **A.** We are carrying quite a few vacancies at the moment, but we have names to those posts now. We have nine members of staff in vetting, so they are going through the Home Office CTC and the G4S clearance, so that is a real improvement from where we have been in the past. Recruitment in the local area is really slow, so you obviously have nurse shortages in the area. We are finding it difficult to recruit but we have opened up posts to paramedics,

as you know, and we are getting many more paramedics applying. Looking at the skill mix and everything like that, that is one area that we have looked at, and we have put a restriction on how many paramedics we can have. The paramedic we have at the moment is really enjoying it.

77. **Q.** Who is that - Stuart?
78. **A.** Yes. He has never done this sort of environment before, so it is really interesting to see.

79. **Ms Lampard:** So three of your new nine are paramedics?
80. **A.** Two of those nine are paramedics and we have one in post already. We have four HCAs there, I believe, and two nurses, from the top of my head.

81. **Mr Marsden:** How have you managed that improvement? I am interested to know, because Sandra was certainly saying that recruitment has been a longstanding issue.
82. **A.** About a year ago, we had a pay review. We looked across the local area and at what the NHS was offering, because they are our main competitor. Our salaries at the moment are really competitive, and that is an improvement. We have had a real recruitment drive and we have refreshed all of our adverts, making them more attractive and listing a little more of what we do. That has helped and, when staff come for interviews, they are asking really inquisitive questions about the services we provide. 'How do you manage this? How do you manage mental health within the centre?' It is really good. It goes on and off, really.

83. **Q.** When you recruit, do people have the opportunity to come in or is it the same as it is for DCOs? They will go to an ITC –
84. **A.** We interview in-house and we tend to do it in our office in the middle of the centre, so they get a look around the centre on their way in. They get a vibe of the centre, and that has worked quite well. Often, you can say to someone that it can feel quite tense sometimes, with no windows for example, but people don't really gauge that. Then, when they are in the centre, it is really not that bad, that there are no windows – you can't really tell, so you don't even think about it. I think it is useful to have interviews in the centre.

85. **Q.** You have not had problems with the Home Office over bringing people in?
86. **A.** No, because they come in as a visitor. We make sure that they are searched at the gate, and they are escorted at all times. They are coming in as a visitor.

87. **Q.** They have that opportunity to get an idea of the noise and so on.
88. **A.** Yes. They hear the noise and they see the patients wandering around the centre. They have the opportunity to see the different things that we have in Healthcare.

89. **Q.** They are fine, that they have to open and close a door, and lock it.
90. **A.** Yes, things like that are some of our questions - does the environment phase you? How do you feel about locked doors? I have heard people say that they don't deal well with locked doors and that would be somebody where we would say that this isn't for them. However, if someone has worked in a secure forensic unit would have absolutely no worries. You can sort of gauge, in the interview process itself.

91. **Q.** That is really helpful. Turning to your own situation, you report to Kerry. Do you have supervision? Do you have an EDR? Have you had an appraisal recently?

92. **A.** We have fairly regular one-to-one discussions.

93. **Q.** With her?

94. **A.** With Kerry, yes. It would effectively be clinical supervision but, for me, it is not clinical. An EDR? I haven't had one open to the present time, but I have been asked to prepare –

95. **Q.** Have you had one at all since you came to work?

96. **A.** Yes, I have. I didn't have one in my first year, and my second year I didn't. In my third year, I had one, but it wasn't closed.

97. **Q.** Do you have a personal development plan?

98. **A.** Last year, I did, and I achieved my objectives. This year, I don't have any objectives set at the moment. We made our own team objectives on site, including reducing patient 'did not attend' rates for appointments, and to improve the levels of manager training. They have gone really well. There are a couple of team objectives that we have done on site, and that is working with the clinical staff, the non-clinical staff and management. I have been given a course to do. I am not sure whether you are aware but, like the DCOs –

99. **Q.** Corndel?

100. **A.** Yes, Corndel, so I am doing the level 5, the Institute of Management.

101. **Q.** Are you getting the opportunity to actually do it?

102. **A.** In the last three weeks, yes. I have raised that with Kerry because, about a month ago, I was really struggling to make time to get this done in my own time at home.

103. **Q.** You're meant to do it at work, aren't you?

104. **A.** Yes, it is 20 per cent of your working hours per week to do it.

105. **Q.** Which, for you, is proving - ?

106. **A.** It is proving really difficult, and that is quite common across the other managers, because a lot of the SMT, Head of Security and everyone like that are doing it as well. That is proving quite difficult for them, but I was starting to plan even taking a half day a week, to really concentrate on it.

107. **Q.** What is it like?

108. **A.** It is a really good course. In a first manager's post, with no previous managerial experience, it is taking what I am doing at the moment and learning lots of new techniques, and learning different ways to support staff and to manage potentially difficult staff as well. It covers things like how to improve team morale and everything like that. I am only on unit 1 at the moment.

109. **Ms Lampard:** Did Kerry agree that you should have some time to deal with this?

110. **A.** Yes, Kerry supported me on that.

111. **Mr Marsden:** Could I just have your view? The sort of healthcare work that goes on in the centre is not your job, but you see parts of it and you understand the

interactions. Could I just talk you through some of the things we have heard? First of all, if you talk to detainees, there is a sense that in Healthcare the GPs take the Home Office view, and they 'don't ask about my immigration case and don't see me as a person with a health problem, and they are not very sympathetic to me.' What would your response to that be?

112. A. I think the GPs have a very proactive approach with the patients. Sometimes, the questions do relate to their case. If a patient is coming to them 'How long have you been in detention? Have you been in detention six months?', then that might answer the question as to why they are feeling slightly depressed and very low. A couple of detainees have asked me why the doctor is asking about their case, but I don't know whether this is something that the doctor is not explaining to them. 'I'm going to ask you about your case. You have come to me and you are depressed and anxious and stressed, how is your case going? Is it your case that is making you feel like this? Is it the centre that is making you feel like this?' That might be something to pick up with the doctors and say almost that they should explain themselves a little better to the patients.

113. Q. And say, 'I am asking this because it may be relevant to your health.'

114. A. Exactly. The patient needs to be aware of that. I wouldn't say that they take the Home Office on their side in the case, really. Ultimately, from my understanding, the GPs see them as a normal patient as they would see them in the community. One of the doctors has come from the community and one has come from the community as well as Heathrow – one of them worked at Heathrow previously. I can see why some of the patients may feel that, and I think it is a case of explaining that point of view, really. That needs to be looked at.

115. Q. Yes, I can see exactly what you say about the relevance of asking someone about their situation.

116. A. Yes. On some of the patient feedback, especially at Tinsley, and they are the same GPs that work across both, it is that some of the detainee's have seen the doctor's attitude to be abrupt. That is something that we have spoken to the GPs about recently and I believe that that has improved.

117. Q. Yes, we got a little of that from the forums.

118. A. Yes. That is something I have taken up with the GPs, to think about how they are conducting themselves – to remain professional but to be a little more sympathetic and empathetic, and understand where the patient is coming from in the centre.

119. Q. Have you spoken to them?

120. A. Yes, I have spoken to the GPs about that.

121. Q. Have they taken that?

122. A. Yes, they have taken it on board and said they completely understand and it is fine – they didn't realise how it was coming across.

123. Ms Lampard: I want to ask you about detainees who are evidently not coping and are distressed and properly depressed. As I understand it, if they are particularly vulnerable as well because of that, they are put on the E wing. Our impression is, and this is no secret, that E wing is also used to put in people who they think will kick off if they are going to be removed. Sometimes, people who are bullying are put in, who honestly just need to be

segregated from other people. It is also the thoroughfare for Rule 40 and Rule 42 detainees. In my view, that is a pretty toxic mix of people, and probably not terribly appropriate for people who are suffering some sort of distress. I know that there was some discussion about building a care suite at Tinsley, but did they ever do that?

124. A. Yes. There is one at Tinsley House, which is a Healthcare care suite.

125. Q. What does it look like, in your view?

126. A. Very, very clinical. It has a big pane Perspex window, with very limited privacy, I would say. I would say that if you were observing someone who was under constant supervision, who had expressed self-harm or suicidal thoughts, it would be perfect, because you would have a clear view.

127. Q. Do they do constant supervision on the wings as well?

128. A. On E Wing, yes.

129. Q. Only on E Wing?

130. A. Only on E Wing – the two end rooms have two panels that get removed.

131. Q. What is your view of that as a provision?

132. A. I think it is useful if you have someone who is very, very distressed and is actively self-harming, to keep an eye on them, just to make sure that they are safe. Sometimes, I think it can be used very quickly.

133. Q. Do you also think it is actually an appropriate setting?

134. A. It is not an appropriate setting at all. I would say that CSU is an appropriate setting, if it was used for observation, care – almost a care suite area. There are six rooms there and you could make it a little friendlier and softer, just so that people can de-stressed in that situation. For example, if we have someone under a section who is particularly wonderful, then plonking them on E wing is not particularly appropriate, especially if it is being used for Rule 40. I think there needs to be an area of the centre where particularly vulnerable people need to be placed. Often, that can involve Tinsley House – so internal transfers from Brook and Tinsley do happen. Tinsley is seen as a softer environment.

135. Q. How often does that actually happen, though?

136. A. Healthcare put in requests to move people to Tinsley and so if anyone has any particular learning disabilities, for example – if they have severe learning disabilities, we would look first of all to raise that with the Home Office. We would say that we have someone here with learning disabilities, via the 'Adult at Risk' policy, or that type of process. However, if they were really struggling at Brook House, we would try to move them to an environment which was more suitable.

137. Q. How receptive are the Home Office and the centre to moving somebody?

138. A. They are actually very good. I find them very good. If Healthcare have concerns around moving someone, or I know that if G4S have someone who is being bullied, then if they are suitable for Tinsley House, they do accommodate them.

139. Mr Marsden: Does that go to the Home Office?

140. A. That goes to the Home Office, to approve the transfer.

141. **Q.** Okay, but it would be a discussion that you would have with the local teams?
142. **A.** Yes, definitely?

143. **Q.** They would raise it with DEPMU.
144. **A.** Yes, they would raise it with DEPMU, or we would raise it with DEPMU, and that would happen in that conversation.

145. **Ms Lampard:** Are you aware of the Home Office and DEPMU ever turning down a request?
146. **A.** Only if a patient is seen as unsuitable. Due to the family unit at Tinsley House, anyone with any criminal history relating to sex offences would not be suitable for Tinsley. However, they could go somewhere like Campsfield, which isn't as prison-like – their setting is a little softer.

147. **Mr Marsden:** I would like you to tell us about the interaction between Healthcare and the centre. You start the journey with reception - Healthcare's presence in reception is an HCA?
148. **A.** Yes, there is an HCA or a nurse.

149. **Q.** You arrive as a detainee -
150. **A.** I have arrived as a detainee and I will see G4S Secure, and be admitted in a process. I would then need to be seen by Healthcare within two hours of arrival into the centre, by a nurse or an HCA, to have the admission screen completed. The HCA completes the admission screening and a nurse will then sign that off to ensure that, if someone has disclosed that they have asthma, then they have a personal care plan, or if someone has disclosed that they have mental health issues, then they will have the appropriate referrals done. They will be assessed to see whether they need a single room. Everything like that is gone down, to insure that that is covered off.

151. The detainee will then have everything completed by G4S, for admission into the centre. When they are being seen by Healthcare, they would be booked a GP appointment for the following day, this is a five-minute appointment which is classed as a new arrival screening by the GP. That will go through any medical conditions they have raised, or any medication that needs to be prescribed if they are taking any medication that needs to be continued from the community, or other centres. Then, if they need any further routine appointments, we will then book those.

152. **Q.** At the point when you arrive, if you are bringing medication in with you, the detainees' view is that they take it away. Does that happen?
153. **A.** Yes. Each detainee is risk-assessed for their 'in possession' status. If they can't read, write or speak English, and they are already taking their own medication, we will take that away from them and then tell them that they need to contact Healthcare and collect the medication. That would be just so that we could understand their understanding of their taking of medication which applies. After a week, if they are absolutely fine and they understand how to take their medication, we give it back to them. If someone is on ACDT, we would give them their medication.

154. **Q.** What is the balance in the population of people who are having medication? Would most people have their own?
155. **A.** It depends on the medication probably. For things like ibuprofen, cetirizine, or the over-the-counter medications, such as indigestion medication and

anything like that, we tend to give those things in possession, as they are low risk. However, with things like mirtazapine and codeine –

156. **Q.** Something that has a kind of tradeable value.
157. **A.** Anything that has a tradeable value, we tend to keep hold of. We can then monitor compliance and we can make sure that they take the medication correctly.

158. **Ms Lampard:** Anything that is tradeable, they don't have in their possession?
159. **A.** Yes, they won't have it in their possession. Anyone who is risk-assessed as unsuitable to be in possession of medication, they wouldn't have it.

160. **Mr Marsden:** With ACDTs, then, Healthcare has a really important function there. How does that work? Are you called and do you become involved?
161. **A.** We are notified that an ACDT has been opened and then that will come through to Healthcare and the RMNs would be informed straightaway. The RMNs would try to see them the same day, just to check in and say there is a mental health nurse who is able to talk to them. They will attend ACDT reviews and if they are looking to close an ACDT, we would always have an input into that as well.

162. **Q.** Does that all work?
163. **A.** That works really well in the centre, and we have a really good understanding.

164. **Ms Lampard:** Today, for instance, I have just met a detainee who has told me that his ACDT review happened without him being informed, and he was taken off ACDT.
165. **A.** I was notified of that this morning.

166. **Q.** Is that common?
167. **A.** No.

168. **Q.** That is an uncommon thing?
169. **A.** That is uncommon.

170. **Q.** The other thing we were told about ACDTs is that individual DCMs are meant to have a caseload and that, because of the pressures they have been under, they have been palming them off amongst each other, so that people are not having the continuity of DCM oversight. Is that your impression?
171. **A.** Yes, I would say so.

172. **Q.** We have also heard the chaplain criticise a bit, in that he is not necessarily informed of ADCT reviews and that they tend to be done a bit on the hoof. I think your staff would suggest that they do become involved – they have a telephone -
173. **A.** It happens at very short notice – nine or 10 minutes. I think there are time restrictions when an ADCT review needs to happen, like 24 hour reviews or something like that. I believe we need to have more notice as Healthcare, definitely, and then there is time to prepare and to make sure we are potentially seeing the patient on their own –

174. **Mr Marsden:** Yes, and the input that you are making is therefore important.
175. **A.** Yes, exactly, it is informed and meaningful, 'Have you seen this patient?', 'Yes, well, I saw him two days ago but I haven't seen him today on his own.

He has been able to express everything he wants to tell me, but with patient confidentiality, he is not going to want to go through any medical issue with you guys, I feel that it is important that we are aware of when reviews are happening, with the times and that type of things. Then it just means that we are able to manage their time as well, because the last thing we want to happen is that they are meant to be seeing a patient but that patient is then being pushed back, interrupted, or anything else like that – especially for a mental health issue.

176. Q. In terms of mental health problems, and people who have been taking drugs and are perhaps detoxing, what do you think about the service provision for those kinds of detainees?

177. A. They have good access. They have input from substance misuse. Then you have the Forward Trust to do the non-clinical, or some of the social elements as well. I think they have good access. Referrals in from other centres, who are coming from, for example, prisons, come in on very high doses, and not being reduced in preparation for removal, because ultimately that is what we are doing. We run a detox service and that is done with the patient, and they discuss medication. Methadone is a quicker detox, as well as it being more manageable, whereas if someone came along with buprenorphine then we would maintain them on that as well, and start to reduce on that.

178. They have full engagement in their detox programme, with regular reviews with the doctor and regular reviews with all the Forward Trust, if they wish to engage with them, as well as with us. So if they are coming up for their dose-by-dose medication, the nurse will always ask them, 'How are you doing?' If they are struggling, or if they say they need to see someone, that is fine and we will book them in – that is not a problem. It just means that we are seeing them daily and reviewing them almost daily, so I would say that they have good access. I would also say that it is very tricky when the prisons send them on on a higher dose and we are not always notified of flights in advance. If a detainee is on a high dose of methadone, for example, and they are going back to a country where methadone is not accepted and is not available, then we would say that they are not fit to fly, because we can't send them back to a country where they will not have the services to get better.

179. Ms Lampard: Is it the pharmacist who will take responsibility for saying, 'How are you doing?', and alerting the nurse perhaps that somebody is not doing well?

180. A. The nurse will do the controlled drug round. If the pharmacy technician is concerned, or if anyone is concerned really, the HCA will go down, or I will go down and say, 'He doesn't look too well this morning and we want another check on him.' Someone will check on him, definitely and that is one of the advantages of our two stabilisation rooms in E Wing, because they have officers to check on them, and they have the call bells.

181. Q. Are they the same as the observation rooms, those two, or are they separate?

182. A. They are the first two rooms.

183. Q. The obs ones are down at the end, aren't they?

184. A. Yes, that's seven and eight. They are for constant supervision. 'Substance misuse and stabilisation rooms' is what they are called, and they are Room 1 and Room 2. It just means that they have a hatch on the door so that, during the nights, if we need to check their temperature, we can take their temperature through the door. Especially if they are alcoholics, because it is

more dangerous in the night time. It just means that we have access to be able to do regular observations on them downstairs.

185. **Q.** Is that where you would always put somebody who was on –
186. **A.** If they are unstable, yes. If they have not come in on medication from another centre, or if they have been picked up in the community and they have ended up at a police station, and they have been medicated just to see them through, we get them into the centre and make sure that we keep regular observations. They are reviewed daily by the GP and, depending on the patient, it might be that they would need every two hours by a nurse but then, again, that is risk assessed as the days go on. They would normally spend a minimum of five days downstairs. After the five days we would review them again for their suitability to go into the rest of the centre.

187. **Mr Marsden:** Turning to the question about things like use of force, for planned use of force Healthcare should always be present. Are you?
188. **A.** Yes, we are notified. Again, the planned use of force can be at very short notice, if something has gone wrong in the centre. Yes, we are aware. We would have a section on the briefing -

189. **Q.** Do you mean the morning briefing?
190. **A.** No, the briefing for the planned intervention. The officers tick their entries and then they will also have a section to state our role. If they are going to use force on someone with a broken right wrist – then we would say 'Actually, they have a broken right wrist. Please be aware if there is a shield, or if we are putting on locks or anything like that.' If they have asthma, we need to make sure that the officers are aware of that. That is our point to say whether there are any concerns. Then during the use of force, if we have concerns, it is hands off.

191. **Q.** Do people know that?
192. **A.** People are fully aware of that, yes.

193. **Q.** They do it?
194. **A.** I have witnessed one doing it. Very rarely do the nurses say 'hands off'.

195. **Q.** As in, they don't think they need to?
196. **A.** I think it is because they don't feel they need to. Training around C&R is very few and far between, and that is something that needs to be looked at.

197. **Ms Lampard:** Sorry – the training?
198. **A.** The training for C&R, so that nurses are involved in the training. They have personal protection training but I think there needs to be a little more education around C&R for the nurses and their role.

199. **Mr Marsden:** As in, 'You've got them in an uncomfortable position and they can't breathe properly.'?
200. **A.** Yes.

201. **Ms Lampard:** At the moment, all they get is personal protection training but they don't have specific training on what their role is in C&R.
202. **A.** They are told what their role is.

203. **Q.** Who tells them that?

204. **A.** Steve Skitt has done a 'role of the nurse' talk – what should the nurse be looking for, and what should the nurse be doing? As part of the nurses' induction, they don't go to a C&R on their own but they will go with a nurse who is competent at running C&Rs and knows what to look for, physically showing them 'this is what you are looking for in a C&R.'

205. **Q.** If you forgive me for saying so, the idea of Steve Skitt doing the 'what to look for' – I mean, he is not a medic.

206. **A.** I think it is around where the officers should be. If the officer is holding the head incorrectly, how should the officer hold the head and what are you looking for? The nurses know, as part of their orientation -

207. **Q.** I can see why you think there -

208. **A.** I think there needs to be something, and it is not the most pleasant experience.

209. **Mr Marsden:** If you think of the Jimmy Mubenga case, and how easy it is for somebody who doesn't understand the fact that, if you are put in that position for half an hour, you are not going to be able to breathe properly.

210. **A.** Yes, that is just one area that we need to revisit, just to refresh.

211. **Q.** Does Healthcare play a big part in removals charters?

212. **A.** We do our own charters, so we tend to try to base a member of Healthcare downstairs around the charters, or to go down the regularly, just to make sure that everything is okay. We ensure that medication is already to go, so that they have everything that they need. Some of the charters are 'no notice', so it is tricky to prepare detainees for when they are going home, especially if they have medical conditions. It is about making sure that they have sufficient medication. There are questions like, 'If you go home, do you know where to access – or can you access?' Yes, there is some education really, to the detainees around what they can potentially expect, even though they know that, for themselves, they are not going back and they are staying here. It is just trying to prepare people for that, which is also something we are trying to do.

213. **Q.** Having paramedics makes first responses a slightly different prospect and must have transformed things.

214. **A.** Yes, they are a real, real asset, and something I would recommend for other sites.

215. **Q.** Presumably, before paramedics, nurses went as first response.

216. **A.** Yes.

217. **Q.** Actually, people aren't taught first response as a nurse.

218. **A.** No.

219. **Q.** Unless you worked in A&E.

220. **A.** Yes, and that is something we ask in our interviews. That is a desirable – that they have acute A&E experience. We have members of staff who have worked in A&E, which is a real positive for us.

221. **Q.** But someone like Stuart, going into first response, where someone is perhaps in respiratory distress –

222. **A.** It will not be something that he has not seen before. He is very good in first response and takes the lead. Yes, paramedics are fantastic.

223. **Q.** That must make the nursing staff and the Healthcare staff feel much more comfortable.

224. **A.** Yes, much more comfortable, definitely. There has been the risk of Spice.

225. **Q.** In overall terms, Michael, relations between DCMs, DCOs and Healthcare staff - how would you characterise them?

226. **A.** On site, very good actually. I think things go well and we have good communication and good relationships with the officers and DCMs. There has been a very fast churn in the operational staff and DCOs especially - we have many new officers and lots of inexperienced ones. That is one of the risk areas, in that we have many inexperienced staff, and sometimes potentially an unsettled centre.

227. **Ms Lampard:** Could I just put it to you that some officers have suggested to us that the response of nurses is sometimes a bit slow. They are a bit slow to come and –

228. **A.** Is that in an emergency?

229. **Q.** If they are anxious about something, they sometimes feel that the nurses aren't taking it seriously enough and coming quickly enough.

230. **Mr Marsden:** It is worth saying that there is probably some anxiety on the part of particularly the less experienced officers, about dealing with Healthcare issues. There is anxiety about 'What should I do? I don't know how to manage this.' They can feel anxious about handing out paracetamol and things like that.

231. **Ms Lampard:** Also, those too, I think it is fair to say, dealing with incidents. I think substance misuse is the issue that makes them particularly windy and they sometimes feel that the nurses don't quite understand how windy it makes them feel. Nurses are used to dealing with it and they know that it is not fatal, whatever is going on.

232. **A.** Yes. We do a talk on the induction. From Healthcare, it is of Sandra who will often go and do that conversation about the issue of paracetamol, and about communicable diseases and substance misuse. It covers what we are here for, what we do, and what we *can* do on site, and the sort of things we cannot manage on site.

233. **Mr Marsden:** I think you put your finger on it when you said that there are lots of inexperienced officers around. Probably, in that sort of interaction between lay officers and Healthcare professionals, there is a good deal of hand-holding needed at the moment. That is probably what we are picking up.

234. **A.** My concern is around being slow to respond and I would *totally* disagree. Totally.

235. **Ms Lampard:** I suppose the question is, what is a real response, and what is just a 'bit of anxiety'?

236. **A.** If it is a case of anxiety, the nurses have no issue about going to it because they would rather go and make sure. That is a good thing, if an officer is raising an alarm that they are concerned and not happy, that is why they raise it. The use of red and blue codes needs to be looked at very closely. A first

response, or medical response, for me, isn't good enough. If you keep it for code red, or code blue, then the nurse knows what they are going to as well. If it is a code blue, we should be calling an ambulance.

237. **Mr Marsden:** Do you think that is weakened?
238. **A.** It is very weak. Officers not knowing where officers are in the centre, if they push their panic alarm, is a risk. We have it where we are waiting three or four minutes for an officer to respond to someone pushing his or her panic alarm. The nurses with their emergency bags are saying, 'Where I am going? I need to get somewhere, but where am I going?'. Control aren't relaying that message to the staff and so the first responding officers from Healthcare don't actually know where to go.

239. **Q.** Do you have designated first responders?
240. **A.** In the day, for Healthcare? Yes.

241. **Ms Lampard:** The officer has identified an issue and they have phoned Healthcare?
242. **A.** No, it might be that they have pushed their response button. If they push their response button, it comes up on the radio as an emergency, and the control room alert that it is an emergency. They will often say, if it is on Pearl, the call sign is there but where is your location? No one is coming back to us and often, the Oscar 1 will say, 'Who is assigned to that radio?' and then ask where that person is meant to be working today. Then they are looking on the cameras. That is where the nurses are getting anxious, and saying that they need to get there, but they are asking where they are going. They will often radio to control, to say that they need a location because they need to get there. I don't know whether that is a training issue with control, or staff pushing the response buttons but not then communicating where they are.

243. **Ms Marsden:** Could that be inexperience?
244. **A.** That is potentially inexperience, and that potentially might be where the officers feel that they are not responding quickly enough. If you don't have that information –

245. **Q.** Yes, that vital piece of information about where you are.
246. **A.** Yes, exactly. That is so vital in the centre.

247. **Ms Lampard:** I am sorry to interrupt, but could I just ask you one other thing about training? You told us that Sandra goes to the ITC and gives an initial talk. So far as we understand it, mental health training is delivered by the safeguarding team, on site, so that is James Begg and Conway.
248. **A.** Yes.

249. **Q.** But neither of them have had any training in mental health, and they have had no training as a trainer.
250. **A.** No, which is inappropriate.

251. **Q.** Everybody is telling us that that is a need that they have.
252. **A.** We used to have the Sussex Partnership NHS Trust as our mental health provider.

253. **Mr Marsden:** Yes, and their CEO told me that they withdrew.
254. **A.** They have withdrawn and we now have a new provider.

255. **Q.** Who is that?
256. **A.** Elysium Healthcare. They are a private company and they run secure facilities across the country. One is two miles down the road at Farmfield hospital, and that is where we are accessing our psychiatrists and our psychologists, so we have actually enhanced our service.

257. **Ms Lampard:** What is it called?
258. **A.** It is Farmfield hospital, and it is Elysium Healthcare.

259. **Q.** Thank you.

260. **Mr Marsden:** They took over from Sussex Partnership?
261. **A.** They took over from Sussex Partnership with no gap in the service. It is really positive. There was a formal handover with Sussex Partnership, and so the two psychiatrists met on site and went through the current caseload. They went through what prescribing trends there are, and things like that.

262. **Ms Lampard:** Do they provide psychologists?
263. **A.** We used to have occupational therapists with Sussex Partnership, but we have actually enhanced the service. We are not using occupational therapists but we are using psychologists. That is really good. We are looking towards the new mental health specification for our service as well, which is really good.

264. Just coming back to the Sussex Partnership, there were talks between G4S, Secure, and Sussex Partnership, for Sussex Partnership to deliver the mental health training to their new ITC. I think it had the title of 'Mental Health First Aid', or something like that. That was ongoing for at least 18 months to two years. That was brought up in our partnership Board, we invite G4S and the Home Office.
265.
266. **Mr Marsden:** Who was responsible for that? Who was having that discussion?
267. **A.** I believe it was on site, so it might have been Ben with the West Sussex Partnership.

268. **Q.** It was never resolved?
269. **A.** I don't think it was ever resolved.

270. **Q.** Sussex Partnership weren't coming here and delivering?
271. **A.** No.

272. **Q.** Do you know why the Sussex Partnership withdrew? Did they tell you?
273. **A.** The service wasn't big enough for them. They wanted more input, but it was something that wasn't achievable. However, I feel that we have done very well and we are still able to access Langley Green hospital, which is the community beds. We actually sectioned a gentleman yesterday, we have made contact with Langley Green and they are coming on Tuesday to assess his suitability for there. Nothing has changed, that way, but it is just the in-house provision for psychiatrists coming in to -

274. **Q.** Turning to the question of governance and Healthcare, there is a quality meeting, which I think is quarterly?
275. **A.** Yes, it is a quarterly quality meeting.

276. **Q.** Tell me how it is governed. How does it keep a handle on what is going on?

277. **A.** We have regular meetings with practitioners through our quarterly quality meetings. We have a Partnership Board meeting and contract review meetings, we have a Healthcare meeting - one a month, when the NHS would be present, and the Home Office and G4S on site. Our commissioner opened it up to the other parties as well, saying 'We would like you to attend because we would like you to see what we do. We would like you to have an input into what we are doing and we would like to tell you what we are doing.' That is really good, because it really promotes shared working.

278. We have a monthly internal governance meeting with our staff on the floor as well. It is just about sharing all the information that we're are being told we need to deliver, as well as any issues, risks or anything from the floor, into these governance meetings, so that it is being taken all the way through. We have the Head of Clinical Governance as well on site quite often, which is really positive. Yes, the whole governance process is pretty good.

279. **Q.** I have a small question - Hibiscus. There was personal protection training where Hibiscus were present.

280. **A.** Yes.

281. **Q.** There was a member, or perhaps more than one member, of Healthcare staff who went to it, and apparently raised concerns about performance. What happened following that?

282. **A.** Following that –

283. **Q.** You know that there was a complaint?

284. **A.** There was a complaint and we had two members of staff suspended and I believe two trainers were suspended. Our two members of staff had a full disciplinary – a full investigation and full disciplinaries. One was a disciplinary and one didn't go to a disciplinary.

285. **Q.** Was there a warning to both of them?

286. **A.** I think the first person came back to work. She was warned about any future conduct but actually, through the investigation, it was seen that she actually hadn't done anything wrong, I think, apart from not flag that there were issues. The second person did go to a disciplinary and was given a written warning, I believe, or a verbal warning around future conduct – I think that was the outcome. However, they have both come back to work and, since then, we have had a real drive on 'speak out', and we have had a real drive on G4S values.

287. **Ms Lampard:** The second one didn't need a warning, but the first one, the main one, did.

288. **A.** The second one did, has been warned on future conduct and will be monitored very closely. I have lost track of what I was saying now. Yes, in the staff meetings, there was a real drive on 'speak out' again. Health now has G4S value cards and there are scenarios that we read to the group and then we ask them to talk about it – what G4S value does it cover, and is this something we should be reporting? If it is, why? It is about getting that understanding out there much more, and really trying to drum it into staff around safeguarding and 'speak out', and raising concerns. We had a nurse who came to us around a C&R to raise a concern, that was investigated immediately, the CCTV and the footage was viewed - it was actually fine. It

was her understanding around the use of a hold, she didn't understand the hold.

289. **Q.** That is your point about people needing a bit more –
290. **A.** They need a bit more training and guidance, about a good hold and a bad hold.

291. **Ms Lampard:** Just while you are on this subject, you have a small team and you can look after that issue and you can drum it into them. What is your impression of the overall rest of the staff in the centre, and their grip on their obligations?
292. **A.** I think it is raised much more, since *Panorama*, definitely. It should never have reached that stage and it is my opinion that what happened was atrocious. I feel that there needs to be something regular. We do a monthly staff meeting and we are saying it every single moment, so that staff are fully aware of it. I think that just needs to keep happening, and that we should not stop doing it.

293. **Mr Marsden:** It is about managers repeating things.
294. **A.** Yes, repeating and repeating and repeating.

295. **Ms Lampard:** Do you ever go to the staff forum? Is it ever mentioned there?
296. **A.** I don't go to the staff forum. Although we are G4S, it falls under a separate business and so we are very different.

297. **Q.** It is not clear to us, what the opportunities for that are here. They don't do regular debriefing.
298. **A.** They are not regular staff forums. They happen every couple of months. Whereas, if you do have them monthly you capture different groups of staff, and you are capturing more staff, and more staff are having regular input with the senior managers, the DCMs and the staff on the floor. I just think it would be a real benefit and, potentially, just centre meetings would be a good thing, because there are lots of different agencies that work in the centre. If the cleaner sees something going wrong, do they know to speak out? That is the other point: if there is a centre-wide meeting where different represents come to the meeting, and then feed that back –

299. **Mr Marsden:** It is quite possible that a cleaner might see something.
300. **A.** It is another fix, it is another level, to say 'this is what we are doing and this is how we can meet different levels of staffing, different teams and different staffing groups.' It is about educating, at the end of the day.

301. **Ms Lampard:** Yes, and the other issue of course is that with incidents like *Panorama*, one would expect some pretty focused work on debriefing, but that doesn't happen. Incidents do not lead to debriefs here.
302. **A.** No, they don't.

303. **Q.** Neither hot nor cold.
304. **A.** In Healthcare, we have a very basic thought, but it is our first step into debriefing. It is for the staff who have attended responses, or who have attended at an incident, where they can sit down and do the basics, what went well and what didn't go well? What can we learn?

305. **Q.** Is that just for Healthcare staff?
306. **A.** That is something we have introduced very recently in the last few weeks.

307. **Q.** For Healthcare staff?
308. **A.** Yes. That just picks up on learning lessons.

309. **Mr Marsden:** Who introduced that? Was that your idea?
310. **A.** Yes, myself and Jade at Tinsley introduced that. One of the nurses wrote and said that she wanted to have some debriefing. That has been happening.

311. **Q.** My final question – do you feel valued by G4S? Do you think they look after their staff? You can have the recording off.
312. **A.** I would say don't quote, definitely, but I would say no. I was say there was no valuing. It is a very, very difficult environment and, until you work in it, or until you do it day-to-day, you will never see the stresses that staff go through. You will never see the difficulties, and you will actually never see the good work – you don't see that.

313. There has been a lot of pressure from *Panorama* and I would say that they don't recognise the vast improvement that there has been, and the vast amount of work that has to go in. When you get things like this, for example, it is a case of, why is it still happening? Well, it has still happened, but we don't know why it has still happened. We don't know why it has happened. If you are doing these regular meetings and you are speaking to staff about 'speak out', why are staff not doing it? I think it essentially to do with staff confidence, and differentiating again. If you have a new member of staff, and a new person on protection training, who has never done any training like that before, do they know that staff shouldn't be swearing so much in a training session? In their heart of hearts they might do, but they might think that this is how all the sessions go, so are they preparing us for the potential environment we are going into? I don't know. Again, from what I remember from training, it does not sit comfortably with me at all. There is no need for that at all.

314. **Ms Lampard:** Michael, I have found that really helpful.

315. **Mr Marsden:** If there were two or three things that could be done to improve Healthcare, what would they be?
316. **A.** I would say that, for the Healthcare provision, a dental suite would be fantastic. It would reduce patient risk in waiting for an appointment at the hospitals, and it would reduce the security risk of taking people who are a potential escape risk out of the hospital. It would reduce staffing costs. It would reduce on lots of different things: it would have a cost to it but I think having a dental suite would improve the service.

317. The way Healthcare looks at the present time, it is very, very scruffy – but that is in the process of being done. I have had the colours today, so we are having a bit of a refurb. It is just about making it more of a clinical environment. There are things that we have raised on inspections – just basic things like flooring, which you see in hospitals, where it curves up the wall, but we don't have that. It is not good and it is not clean - it is not a clean centre.

318. **Q.** We picked that up.
319. **A.** We are not a clean centre, and that is picked up by HMIPs. We raise it on a regular basis but being told that we are 'not clinical cleaners' isn't the right answer.

320. **Q.** This is Aramark?
321. **A.** Yes.

322. **Ms Lampard:** Well, they are not cleaners either.
323. **A.** No, but that is my point: they are not cleaners. That is the difficulty at the moment and it would make an improvement. It would also be an improvement for the patients, because it would make them feel that they are coming to a Healthcare centre.

324. **Q.** It would raise their confidence levels, wouldn't it?
325. **A.** It would, and it would raise morale potentially. The rest of the centre looks quite nice now that it has all been painted, and the doors have been painted. It looks fresh, albeit not as clean as it should be potentially – but it does feel a little fresher, but that is something that staff should have picked up on as well.

326. **Mr Marsden:** Michael, thank you very much – that has been really helpful. We will send you a typed transcript and, when it arrives, it will be password protected. If you ring the office, we will give you the password. If are fine with it just say so, and that you don't want to make any changes or, if you would like to make some changes, please do.
327. **A.** Thank you.

328. **Q.** Thank you for your time. You have been very helpful.

[*Interview concluded*]