Confidential

Independent Investigation into Brook House

Wednesday, 17 January 2018

Interview with
Sandra Calver
Head of Healthcare,
Immigration Removal Centres, G4S

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

1. **Mr Marsden:** [*Introductions*] Sandra, thank you very much for coming to see us. To get things off to an easy start, I am sure it is going to be easy anyway, just tell us what your job is, what your responsibilities are, a bit about your background, and how you have come to be here? Start with that and we will take it from there.
2. **A.** My current role is Head of Healthcare for the immigration removal centres held by G4S, so I work over Brook House, Tinsley House, and Yarl's Wood Immigration Centres, so I cover three. I started at Tinsley House in 2004, as a night nurse, when the healthcare was seconded by Saxonbrook Medical, and that is where I started my career in immigration removal centres.

3. **Q.** Having done what before that?
4. **A.** I worked mainly at Addenbrooke's Hospital, 16 years in Cambridge. We then moved our family down to this area. I went to Crawley Hospital for six months and that was very different from a very busy Addenbrooke's Hospital. At the time my husband was doing recruiting work, and they phoned to put an advert out for here. He went "Hold on, can I speak to my wife first?". That is how I got into this role.

5. **Ms Lampard:** What was your role at Addenbrooke's? Were you a staff nurse?
6. **A.** I was a night nurse practitioner. I covered the bleeps and covered 10 wards at a time.

7. **Mr Marsden:** Crawley would have seemed very different, wouldn't it?
8. **A.** Yes. They didn't tell me about reconfiguration at Crawley when I came down for the interview, so I thought I was still coming to an A&E department with busy wards. When I got here it was "We are going into an urgent treatment centre rather than A&E, and we have only got rehab". I did six months, I was very bored, and it wasn't for me at all. That was the shortest job I have ever been in. I have always been a long stayer in my work, but I just could not cope with the boredom of it.

9. I came to the immigration in November 2004. At the time I had young children, so I worked predominantly night shifts. There was just four nurses, because we only had Tinsley House at the time, so it worked out well, because two of us did nights and two of us did days, and we covered the shifts between us.

[*Pause in recording*]

10. Then the contract continued at Tinsley House under Saxonbrook Medical, and the nurse manager left. I then became the nurse manager, working days and night shifts. We then opened Brook House in 2009, so I was then

instrumental in setting up the Healthcare Unit here, along with the doctor that was in charge at the time and employing a lot more staff to cover both sites.

11. Saxonbrook Medical continued to have in the contract until 2012, when G4S Health took over the contract, and at that time I was then moved from nurse manager, to local lead. They didn't have a Head of Healthcare position at that time, so I was the senior nurse on site.

12. **Mr Marsden:** Day-to-day, now, what do you do, given that you cover the three sites?
13. **A.** At present time we don't have a clinical lead here, she left last week, so I am based more here at Brook at the present time, but what I was doing was I had clinical leads at both sites, I split my time 50/50. I would visit Yarl's Wood every week for a couple of days and then I would be down here. I look after the senior management of the clinical leads, ensuring the contracts are running appropriately, speaking more with the commissioners and doing more contractual issues.

14. **Ms Lampard:** The clinical lead I met, didn't I, in one of the meetings?
15. **A.** Christine Williams?

16. **Q.** Christine Williams, with dark hair?
17. **A.** Yes, and she has recently left. She had hearing issues – you would have probably recognised it by her speech. She left on 5 January, and that was due to retirement, it wasn't due to anything else, and she did her three months' notice.

18. **Mr Marsden:** Your job is across the three sites, and it is a managerial, liaison with the commissioners, liaison with managers.
19. **A.** Yes, and being the next step-up for G4S Health. We have a regional clinical manager, who covers the whole of all the prisons and the immigration removal centres, so she obviously can't be here, or the phone.

20. **Q.** Is she your line manager?
21. **A.** She is. That is Kerry George, and she has only been in post since September as well. There has been quite a lot of changes within the managerial structure in G4S as well.

22. **Q.** In terms of Brook House, what services, what health services, just big pictures, what health services are offered to detainees?
23. **A.** We have 24-hour nursing support, we have seven days a week GP cover, that six hours a day weekdays, three hours a day at weekends.

24. **Ms Lampard:** Hang on, you are going to have to speak more slowly so I can take it all in - I'm sorry.
25. **A.** It's alright. We have 24-hour a day nursing cover, no inpatient beds, so everybody does need to be independent in care, so we don't do any social care. We have GP cover seven days a week, and that is six hours weekdays, and three hours weekends and bank holidays.

26. **Mr Marsden:** Is that for G4S employed GPs?
27. **A.** We contract out to the GPs. We have a private company called Doctor PA; they have taken over the GP contract.

28. We have mental health nurses on seven days a week, we have a psychiatrist who comes in once a week, and they are subcontracted from Sussex Partnership Foundation Trust. They also do an emotional health group once a week, which gives coping skills to detainees.

29. **Ms Lampard:** Is that led by the mental health nurse or the psychiatrist?
30. **A.** That is led by Sussex Partnership Trust. They have an occupational therapist that comes in to lead it, and then our mental health nurse will also sit in on that as well, so we can continue it through for the rest of the week. The mental health nurses will do talking therapies, they will do coffee and chat groups, they review all the ACDTs and sit on all the ACDT reviews.

31. **Mr Marsden:** In terms of somebody who is presenting with a physical problem – I don't know, a detainee who has type 1 diabetes, or somebody who suddenly becomes unwell, what sort of provision is there?
32. **A.** On arrival, they are all seen by a nurse within two hours.

33. **Q.** In reception?
34. **A.** In reception, and they are also given a doctor's appointment to see a doctor within 24 hours.

35. **Q.** All of them?
36. **A.** All of them. A lot do not turn up, but they are given that appointment, we have an hour's slot, they all turn up, they have five-minute appointments. They are only shortened appointments because it is the initial appointment. If they do have a chronic disease or lots of medication, we will make them a longer appointment. GP appointments are set at 10-minute appointments, the same as they would be in the community, and if we did need double appointments we would double the slot.

37. **Ms Lampard:** Do you audit all of this, for instance, the two hours, the seen within two hours, the seeing the doctor within 24 hours.
38. **A.** Yes, it is all part of our HJIPs, which is Health and Justice Indictors of Performance, and that is put through to NHS England every month. That is all the data is on there.

39. **Mr Marsden:** They have their health clearance, or they have a health assessment in reception carried out by one of the nursing team?
40. **A.** Yes, that can be a trained or an untrained. If it is an untrained nurse then the admission screening is overseen by a trained nurse, and they actually document that they aren't correcting them. If they have medication, that it is being correctly given.

41. **Ms Lampard:** What is an untrained nurse?
42. **A.** A healthcare assistant.

43. **Q.** Okay. Will the nurse be there at the same time?
44. **A.** No, so they will review the screening.

45. **Q.** What percentage are done by healthcare assistants?
46. **A.** A large percent. I would say probably 70 per cent, because it is a template, it is a "Yes/No", a lot of it "Have you got this? Have you got that?" and then they can put them through to the appropriate appointments, if required.

47. **Q.** Let's just think about this. If you had somebody who came in with quite severe underlying mental health problems, as well as the stress of being here, give them medication, that sort of thing, you would be seen probably by a healthcare assistant in reception. When is the first time that you will actually see a fully trained health professional?

48. **A.** We can see them. The nurses there, the healthcare assistant would call them down, so if required, if we had somebody severe, a nurse would be called immediately.

49. **Mr Marsden:** If the healthcare assistant recognises that they need to.

50. **A.** Yes. They are trained in mental health awareness. All our nurses are trained to ILS standard, including our healthcare assistants. We over train our healthcare assistants.

51. **Ms Lampard:** ILS?

52. **A.** Intermediate Life Support - sorry. Nurses do talk a lot in acronyms, which is very bad. Whereas a healthcare assistant would normally be trained to basic life support, we upskill of ours and give them triage training as well.

53. **Mr Marsden:** If the detainees come into the centre, they get their opportunity to have a GP appointment, which they will or won't take up, how do they then access health services? If they have been there a week?

54. **A.** Seven days a week, 365 days a year we have a two-hour open triage clinic every morning from 9.30 to 11.30, no appointments are needed, but then any problems they come in and see a nurse, and that is the trained nurse they go in and see. Then they are triaged with whatever issue they have. If required, a doctor's appointment will be made.

55. **Q.** How quickly?

56. **A.** Doctor's appointments at the present time are running four to five days, but we do have emergency appointments that, if there was anything urgent, we have a couple of embargoed slots that they would be seen on the same day. Though triage appointments are in the morning, the doctor arrives here in the afternoon, so anything that is urgent we will get a doctor to see the same day.

57. **Q.** Okay. In terms of the nursing team, the medical staff's relationship with the centre, just describe that. How does it happen?

58. **A.** I think it works very well here. We have always had a very good rapport. I see both sides, from both Yarl's Wood and here. Working with G4S, and G4S, we do work very well together, and we do share relevant information really well. When I first moved to Yarl's Wood, and they were Serco, I found there were a lot of boundaries, because they were saying "You are G4S" and I found that there were a lot of boundaries. We have got rapport much better at Yarl's Wood, but it has taken a lot of time, whereas here, we are almost like one company, it is just that we are a different branch, and I do find that works a lot, lot better. I have a weekly meeting with the Deputy Director, Steve, if we have problems that escorts weren't getting out on time, or if we had people not being presented when we want them to, then we can raise that, and vice versa – if he has any issues, then he can raise them to me. We try and get that so it doesn't build up into any crisis.

59. **Q.** Let's come back to your involvement in the running of the centre in a moment. Just tell me a bit about the commissioning arrangements for healthcare?

60. **A.** We are commissioned by NHS England. Nick Watkin is our Commissioner.

61. **Ms Lampard:** Where is he based?
62. **A.** Tunbridge Wells.

63. **Q.** Is that specialist services?
64. **A.** Health and Justice.

65. **Q.** It is NHSE Health and Justice?
66. **A.** That's right, and he covers South East, so it is Surrey, Kent and Sussex, and he has all the prisons and immigration centres in that area.

67. **Mr Marsden:** What is the nature of your interaction with him?
68. **A.** Amazing - he has really good interaction. I can phone him at any time, day or night, and really good rapport with him.

69. **Q.** What are the kind of things?
70. **A.** We had an issue earlier on in the year – just before Christmas, with a mental health bed, somebody that was needing a medium secure bed, so medium secure beds are always a lot harder to come by, he helped us place that bed, and in the end he commissioned a private bed. He has got into a lot of trouble, because he shouldn't have done that commissioning, but he put the patient care first, which is what we all want. The rapport we have is very good. He understands what we do.

71. I do a policy meeting once a quarter of which he is invited to, and if he doesn't make it, his quality lead will also come, Debra Vidler, so she comes to that.

72. **Q.** In general terms what is the requirement of NHS England of G4S in terms of the provision of services here? What are they commissioning in general terms? I am sure it is a long contract.
73. **A.** It is the primary care, which primary care treatment, substance misuse, mental health. We have triage dentistry, because we don't have a dental suite on site, so we have a dentist that comes in from the local hospital who does once a fortnight triage of patients. A lot of our patients we find just need antibiotics or mouthwash, which can be dealt with just through triage. If they do require further treatment we take them up to the local hospital for that treatment, and they get Level 1 dentistry care. We have an optician that comes in, so it is just giving those primary services – the same as you would get if you were in a GP practice.

74. **Q.** What is your sense of how well NHS England understand the health needs of this population?
75. **A.** I think they have a fairly reasonable understanding. We do share a lot of information and if we do get issues, we are speaking to him straight away.

76. **Ms Lampard:** Has there been a health needs assessment?
77. **A.** Yes, that was completed last year in July, that was at Brook House. I have that report if you need me to share it – I can do. Tinsley was shut, they have just undergone Tinsley's health needs assessment last week, because we needed it to be open long enough to get some relevant data. That was only completed last week, and we haven't got the report of that as yet.

78. **Q.** Just give me a flavour of the report in the sense of what are the big issues? What is the need, and do you think, as a result of that health needs assessment, have you had to re-jig things? Has there been a re-think?

79. **A.** With the increase of beds we have had to look at the profile of the nurses, that is the big thing we have been looking at to ensure that we are running enough clinics. Our main issue within Healthcare is the constriction of room space. I could run a lot more clinics who have had a lot more rooms, but we have got very tight restrictions on how many rooms there are available within the centre. That includes even the manager's office is the practice manager, the admin, all in one office, with one phone.

80. **Q.** What are the facilities? Tell us what you know.

81. **A.** In reception I have two reception rooms for admission screenings, and we use those also for the optician's visits and the dentist's visits. If we do get any external practitioners come in, that need to do physical examinations, so if a solicitor wanted a secondary opinion, and they need to do a physical examination, they would use one of those rooms as well.

82. **Ms Lampard:** How many do you have? Two?

83. **A.** Two. You have 24-hour admissions coming in, so they can be fairly busy rooms. Then we have the mental health talking therapy room. We have two consulting rooms, which is run by generally one for nurses, one for the doctors. In the morning, the triage clinic is in both rooms, and we have a pharmacy dispatching area, and then the manager's office, and that is it.

84. **Mr Marsden:** I interrupted Kate's question about needs' assessment. I think you were going to say what is the needs' assessment?

85. **A.** The needs' assessment it is still in major review, we have only recently been sent it. We haven't had the first quality meeting to go through all of the needs on it, but mainly it is mental health provision, ensuring that we have great mental health provision, substance misuse has been brought into that, has improved, and getting further chronic disease clinics going. Recruitment, again, is one of our big issues. We have not been fully recruited since 2012. We rely quite a lot on agency staff. They are all CTC-cleared agency staff, and have been with us for a long time, almost longer than some of our full-time staff. They won't take on a full-time contract because of all the perks they get by being agency – they can take their long holidays and the pay is a lot better. We have persuaded them that pay reviews have been done to see if we can increase recruitment here. We have done RCN recruitment fairs. We have tried every possible way. We have done adverts in the local news to get people in. We have tried so many different ways to get recruitment.

86. **Ms Lampard:** Just going back to this needs assessment, did the needs assessment identify nursing levels and room space?

87. **A.** Yes.

88. **Q.** As I understand it, we have numbers of nurses, room space, mental health provision, substance abuse and chronic disease clinics?

89. **A.** Yes.

90. **Q.** It doesn't surprise me to hear you say that you are having difficulty recruiting.

91. **A.** It is big news today!

92. **Q.** There are added complications. Just give us some idea of staffing levels, even with your agencies.
93. **A.** My vacancies at present time, I have one clinical lead vacancy, and I have one senior RGN vacancy. I have two-and-a-half RGN vacancies, three RMN vacancies, and seven healthcare assistant vacancies.

94. **Q.** Not here?
95. **A.** Yes. That covers Brook and Tinsley.

96. **Q.** Just run me through those again.
97. **A.** One clinical lead, one senior RGN, two-and-a-half RGNs, three RMNs, and seven healthcare assistants.

98. **Mr Marsden:** Those are the vacancies you are carrying?

99. **Ms Lampard:** Out of a needed complement of how many?
100. **A.** It all breaks down, because so many of them do part-time. I have approximately 30 staff.

101. **Q.** For Tinsley and Brook?
102. **A.** For Tinsley and Brook.

103. **Mr Marsden:** 30 funded posts?
104. **A.** Yes.

105. **Q.** But you don't have 30 –
106. **A.** In post, no. A lot of these adverts have been out for some time. We keep looking. We are also looking at the present time whether or not –

107. **Ms Lampard:** It is about a third. You are about a third of your staff down.
108. **A.** Yes.

109. **Mr Marsden:** You have a third of the permanent staff you would have, and therefore, the backfilling is with agency staff.
110. **A.** Some of our staff are doing overtime, bank staff are coming in and helping as well. We tried to increase our pool of bank staff as well.

111. **Q.** Does that get you up to your total?
112. **A.** We do run to the correct profile, but it is just our agency costs are tremendous.

113. **Ms Lampard:** There is a lack of continuity.
114. **A.** Exactly. It is not just the continuity. It is our management; agency staff do feel that they don't have to read this, "Don't have to read that". As much as we push back to agency that they are not following processes, I can't manage them as much as I can manage my own staff.

115. **Mr Marsden:** Yes, as in "You will do it this way".
116. **A.** You always don't get as high standards I don't think. Some of our agency staff are exemplary, but you are always going to get one or two who are not. We have pushed back and said "I don't want this agency staff anymore because they are not following any of our roles". We have pushed that back, but when you have the figures that you have to fill in and get the rota completed it can be very hard.

117. **Q.** I do think I have an understanding about why people wouldn't want to work in this kind of environment. What is your take on it? Why is it difficult?

118. **A.** We are very close to London, so a lot of people can get better paid jobs in London, which is one. We are a very rare part of nursing, I don't think the whole prison nursing is put into a good light. I am still here after 13 years, I have learnt so much in that 13 years about the whole world health, I am still learning today, and that is why I am still here. I am really passionate when I do the interviews about how much people can learn and what they can do. You have one or two nurses, but so many of the younger nurses only want to do it as a dip in and move on, healthcare assistants usually are just moving on to do their next career. To get somebody that is going to stay long term it can be quite difficult to find that right person.

119. **Q.** To make a choice that this is what they are going to do.

120. **A.** That's right. We have a lot more progression of nurses than there ever used to be. When I started it was just literally two nurses that we had progression, now we have so many more levels that they could move forward, so there is career progression that they could have.

121. **Ms Lampard:** Sandra, this is perhaps a difficult question for you to answer, but it would strike me that this reliance on temporary staff, agency staff, all of that sort of thing, and this lack of consistency, and frankly, probably, also a lack of getting into the issues of custodial nursing, which are different for other people. It is a risk factor here, and I would say, perhaps, is in particular a risk factor because you have a population of people who are transient, and therefore you have to be very quick witted about identifying things. They are also very volatile. I imagine that people's moods and their mental health issues change dramatically in a way that they might not in the community, so would you agree with me that, in some respects, whilst what you are telling us is probably a reflection of quite a lot of nursing in the community –

122. **A.** It is a lot harder for us.

123. **Q.** It is probably a lot harder, and you are probably carrying a greater degree of risk.

124. **A.** Definitely. We have been told that out of all our CVs we get, we should interview virtually everyone; I disagree with that. The healthcare assistants we have been told to "interview everyone". Well, somebody that has just worked in a nursing home on night shifts I don't think is suitable for here. It is my personal opinion, but I had an interview last week, and I wanted to stop it after two minutes, literally, because she certainly was not suitable for this environment, and I asked several times in the interview "Do you want me to continue". She said "Yes", but when I asked her would she be comfortable locking doors, she couldn't answer "Yes", so she is a definite no to the post, and she has not been appointed, but I felt it is a waste of my time of interviewing, because I would have not interviewed her in the first place.

125. **Q.** Just see if you can describe for me what you think, because you have mentioned it, would be a suitable person? What is it you think they need for this particular environment?

126. **A.** There is some enthusiasm.

127. **Mr Marsden:** Enthusiasm for -?

128. A. For learning and for the job. For any people I interview my first question is "What do you know about G4S? What do you know about the immigration centre", and they say "Nothing". I think "You are coming for a job, you should actually do some background reading for it". I have come for this meeting today and I have read the Yarl's Wood report, I have looked to see what type of things might be looked at, because I want to be saying the right things and sharing the correct information for you. I just think you need to sell yourselves in interviews and so many people are not doing that. Trained nurses, A&E experience is fantastic, we have also got some of the practice nurses, because they have the chronic disease clinics that they run and things like that, that is very useful. We are a GP service within the centre, so they can run very appropriate ones, we have also, in the last year, started recruiting for paramedics, because we have so many first responses and triaging, they are perfect people in that respect. We are now recruiting for paramedics as well, of which we have a couple on site, they are perfect in their role and get really good responses from both patients and the other staff.

129. Ms Lampard: We met a paramedic who was part of the ITC, actually took up a DCA.

130. Mr Marsden: In terms of clinical practice, there are going to be incidents that require you to attend and do things almost as a first responder.

131. A. Yes, that is quite regular.

132. Q. Yes, but the range of skills that you need to practise here?

133. A. Basically, from doing your blood pressure up to life support. We have phlebotomy, we take our own bloods on site. We want to do as much as we possibly can on site to save the escorts having to go out. If we have people that have cuts, can we glue the wounds to save them going off to hospital. The more we can treat on site, the patient gets better care by being quicker, we want to try and do as much as we can here.

134. Q. People will feel a greater sense of ownership if they glue the wound.

135. A. We had a gentleman last year that self-harmed quite severely and had severe burns, we got the burns clinic from East Grinstead, they came to us to do the wounds and showed the nursing staff how to do the wound dressings, and then the nurse could see that progression going on. One, it saved the detainee having to go out on an unwanted escort, it meant that we had the escort available for any other urgent appointments we needed to go to, and we saw the improvement, and that patient got improved care.

136. Ms Lampard: That is a good example; other examples, do you have the time with this pressure to upskill the staff, to keep them trained as much as you would like to?

137. A. Not as much as I would like to. With the numbers I have, to try and get the training covering all my rota at the moment is very hard. We have training next week for an Infection Control Lead on one day, the same day I am going on death in custody training. You have to look at the right levels of people for those courses. Nurses have done travel vaccine clinics, because we need to ensure we have those going, so that is a two-day course to get them out on a travel vaccine update.

138. Q. Are G4S good about allowing you the training budget you need?

139. **A.** We have to put a business case forward, but primarily we have been very successful on getting the ones we need.

140. **Mr Marsden:** Do people get clinical supervision?

141. **A.** Yes. It has been poor in the past, but it has increased in the last year. I have increased my senior nurses. My senior nurse numbers - originally, I only had one general and one senior RMN. When I have got them in post, I will have, three RGNs and one RMN.

142. **Ms Lampard:** They will do-?

143. **A.** They do the clinical supervision of all the staff, and I can confidently say that all staff have had supervision this month, which again we are auditing to make sure that is compliant.

144. **Q.** Before this month, how often was supervision happening?

145. **A.** Some of the staff hadn't had it – we had it increased for the last six months, so some people have had it two to three monthly. RMNs definitely have had it monthly because theirs is separate. I have only had the one senior RGN – she could not get around everybody. Some staff hadn't had any for three to four months.

146. **Mr Marsden:** You have given us a bit of a description of your relationship with the commissioners, and you said you meet regularly with Steve, but just give us a sense of how you work with the centre? You have described it as a very positive relationship because you are all part of the same organisation.

147. **A.** I do attend the morning briefing every morning, which is a joint meeting with Home Office, secure and all parties, so if there are any issues we raise them at that meeting, and that is the senior managers' meeting.

148. **Q.** The kind of issues you would raise would be?

149. **A.** This morning I raised that I was on an outbreak call for chickenpox that is happening at Colnbrook at the time, but one of the gentlemen was with us for two days whilst he was in the incubation period, so I have alerted all of our staff that we have 21 days that we have to be vigilant. The gentlemen that he shared a room with have both had bloods taken this morning, they are being isolated at the present time until we get those bloods back to see if they are immune or not, because they both report that they haven't had chickenpox, so we are doing bloods to ensure. It is just any information that I can share backwards.

150. I do confirm that we have escorts out in that day, if we do have anybody on bed watch, I would give them an update. The medical is in confidence, but any relevant update I could give so that they know how long their escorts are likely to be out on bed watch for, if we do have anybody. We have a gentleman at the moment that we are sectioning and we are still chasing on a bed, so I said that we would chase again daily for the bed for mental health. It is just things like that to give them the insight. Nurses will be present on the ACDT reviews.

151. **Ms Lampard:** Sorry, can I just butt in there about the ACDT reviews? There was some suggestion from other staff that some of the ACDT reviews were not being done with the full multidisciplinary team present, and, for instance, the religious affairs people weren't necessarily being told about them.

152. **A.** Sometimes they do phone and they say "We are going to do an ACDT review in the next 10 minutes", that doesn't always help. When the mental health nurse is in the middle of a consultation with somebody who is crying their eyes out, you are not going to say "I have to leave you now", so I think sometimes it would be really beneficial if they could say "The ACDT reviews, this one is going to be at 10 o'clock, this one is going to be at 11 o'clock". That could even be announced in the morning meeting.

153. **Q.** Do you have a sense of how often they might be awry? We will find out ourselves, but how many of them do you think your staff do get to?

154. **A.** Nursing staff do attend the majority. We are involved a lot in ACDT reviews.

155. **Q.** That is encouraging.

156. **A.** If we are not present they do generally phone us to say if there is any input, so we have always had some feedback. It was us that implemented that implemented the Supported Living Plan into the centre as well.

157. **Q.** That was last year, wasn't it?

158. **A.** The year before. We had it implemented at Parc Prison and it was shared at one of our healthcare manager's meetings. Then I brought that back and shared it with the site, because I think it is a really good working tool for both sides, and it is not a medical care plan, it is a care plan for the patient.

159. **Mr Marsden:** You mention you going to the eight o'clock meeting, if you thought there was somebody here who shouldn't be here for health reasons, have you ever made representations?

160. **A.** I have usually raised that beforehand.

161. **Q.** With?

162. **A.** Home Office. I would complete a Part C, but I would also go and speak to Home Office.

163. **Q.** Do you liaise with a particular -?

164. **A.** On site Home Office, unfortunately, the person does change daily, but we do have the on-site Home Office lead that we speak to each day. We had a gentleman that last year was out on a bed watch, and he became critical care. It was at that point I said "He has officers with him".

165. **Q.** Critical care as in physically? You thought he needed to go into hospital?

166. **A.** Yes - he had major cardiac issues. I did speak to the Home Office and they did release him to his family. His family were all present at the time, so he did get released from detention, and we have raised that before.

167. **Ms Lampard:** You liaise daily with the Home Office, do you?

168. **A.** They are at the eight o'clock meeting. If I needed to raise anything else I can speak to them as well, and we sent a Part C through.

169. **Mr Marsden:** A Part C – just explain?

170. **A.** A part C goes onto their movement sheet. It is the DEPMU. People who are on hospital appointments, we don't want them to be moved to another centre, we do what is called a medical hold to save them being moved to another centre, then missing that appointment.

171. **Q.** That goes to DEPMU?

172. **A.** That goes to DEPMU, so don't transfer. They occasionally do still transfer, but we have tried our best to say "This person's care needs to be -". We have a patient yesterday who came in who has a hospital appointment at Addenbrooke's in Cambridge, and we have put a Part C through to say could he be moved to Heathrow, because that is slightly closer, just to try and make that a little bit easier for the patient.

173. **Q.** It is a long round trip otherwise.

174. **A.** It is, yes. We try and continue their care at the hospitals they are at if possible, because you don't want to restart waiting lists and things like that.

175. **Q.** Continuity of care.

176. **A.** Exactly. If they are in the middle of treatment you don't need that restarted. We do try and keep that going as much as possible.

177. **Q.** You are talking to Steve, you go to the eight o'clock meeting and you will, undoubtedly, interact with the officers during the course of the day, the DCM, the DCA go to ACDTs. The CSU - how much time do you-?

178. **A.** One of the mental health nurses who is involved in all of the Rule 40 reviews, Rule 42 reviews, anybody that has moved into Rule 40 needs to be seen within Healthcare within two hours to ensure that they are safe to be on Rule 40. We complete paperwork as well for that.

179. **Ms Lampard:** Are they good about that? Do they make sure that happens?

180. **A.** They do generally phone. It is the night time ones that will often phone the on-call manager rather than the onsite nurse. The on-call manager could be either myself, it could be one of the senior nurses, it could be one of the senior nurses at Yarl's Wood as well. They have all got instructions of letting the site know, and could just phone the site.

181. **Q.** You think there are some that slip through the net, if they happen in the middle of the night?

182. **A.** Yes.

183. **Q.** They will make a decision?

184. **A.** They will still move them to Rule 40, but they haven't had a Healthcare review.

185. **Q.** Do you think there have ever been any issues about that?

186. **A.** No, I wouldn't say there has been, to be fair. Our mental health gentleman who is awaiting a section bed, he is on Rule 40 at present time, but he is still being given access to facilities and exercise and things, but our nurses are going down to see him regularly as well.

187. **Q.** Can we just unpick that a bit? He is on Rule 40 for his own health?

188. **A.** No, he is on Rule 40 for behaviour, he has been spitting at staff, but he is probably spitting at staff due to his mental health issues.

189. **Q.** Why did he get put there in Rule 40 rather than in just the main Eden Wing, which is a more high dependency?

190. **A.** He was on Eden Wing to start with, but unfortunately his behaviour has become a little bit heightened, so for his safety and the safety of others they have put him into Rule 40.

191. **Q.** I understand. Do you think they make the right call about that usually?
192. **A.** Usually, but there has been the occasional time where we feel they don't need to be on Rule 40.

193. **Q.** If you put your foot down, so your mental health nurse has gone down there to do the discussion about whether they should be on Rule 40, have you ever had cases where your mental health nurse has said to you or said to them "No, we don't think this is right"; what happens in a stand-off like that?
194. **A.** It usually goes up fairly high, to directorate level. It is the decision over the director here, so we do get overruled.

195. **Q.** Have you had many cases where you have felt overruled?
196. **A.** No, I would say the more overruling we have had is if we say someone is unsuitable to come into the centre, that can be overruled by the Home Office. If we say somebody was coming in that we don't think we could care for, we can say "Not suitable for this centre", but Home Office will still say "There are no beds elsewhere, so you have to take them". I think that is very unfair, and we have had that before.

197. **Q.** How often?
198. **A.** It is not often, but there are one or two cases.

199. **Mr Marsden:** Can you think of what it was?
200. **A.** It is usually that they need social care, because we don't provide social care. Then they say "They have to come in and they have to be looked after somewhere", well that is not in our provision, so I don't have the nursing capacity to do that.

201. **Ms Lampard:** What sort of things might that be?
202. **A.** If they need help with washing and dressing. We had an American lady in, who was wheelchair bound. She had come over on a flight by herself, so she was obviously not that incapacitated, but she did need lifting into bed, she did need lifting and help with all social care. They had nowhere to place her, so they placed her in the family suite – at the time we had no other families in, but the Home Office overruled that she needed to be in. We said "I have one nurse on shift and I can't do nurse lifting with one nurse", major risk to their lifting and manual handling – one nurse did get injured through it, but they continued to keep her there, because they said that there was nowhere else for her to go.

203. **Q.** You suggest that there was a difference of opinion with the Home Office, about whether somebody should either enter the centre or should go onto Rule 40, where you and your staff take a view, you will usually be overruled.
204. **A.** Yes. When we had the flu outbreak at Tinsley last year, we had a family that were due to come in from the PDA – we had an outbreak call and Public Health advised that they should not be coming. The Home Office overruled Public Health as well, to say "There is a lot of work gone in for the family, so they will come in". They came in, they were released within hours because there was some JR that went on.

205. **Q.** What was the issue, sorry?
206. **A.** We had a flu outbreak in August, we were the only centre to have a sudden flu outbreak, but it put us into quarantine, we had quite a few people with it, and staff were moving between the areas.

207. **Mr Marsden:** When you get overruled, do you talk to your boss?

208. **A.** And commissioners. It can be written as a serious incident, so yes, I talk always to my boss on that one.

209. **Q.** Okay, and your boss doesn't have any –?

210. **A.** No, there are usually discussions go on at higher levels. My boss would probably speak to Jerry Petherick as well because they are on the same level, so they can speak together. I know there have been discussions on food refusals and things like that.

211. **Q.** Can I just talk about two issues? One is drugs and what we saw in the *Panorama* programme, there were psychoactive substances, Spice, very prevalent there. First of all, how do you think drugs are getting in here? It is a question we will be asking lots of other people. Secondly, how do you think detainees who have taken drugs are managed?

212. **A.** Searching has always been a big problem here.

213. **Q.** Tell us more about that?

214. **A.** Up until the programme I had never had a search on arrival, in all the years that I have worked here I have never been searched coming in. I have no issues with being searched because I am not carrying anything, so they can search me as much as they wish, but nobody was searched. We had many staff.

215. **Q.** Why not, as a matter of interest?

216. **A.** Security had never done routine searches.

217. **Q.** How does that compare, say, to Yarl's Wood?

218. **A.** I have been searched more at Yarl's Wood, and even searched on the way out. Yesterday was the first time I had ever been searched on the way out of here.

219. **Q.** No searching at the gate house?

220. **A.** No. Even when I have visitors arrive which I am bringing into the centre, they often aren't even asked "Do you have a phone on you?" It is a major risk. We should only have phones that are allowed into the centre. It has actually been reported "Visitors should not be bringing any phones in". I don't think big enough searches are asked on staff of visitors coming into the centre.

221. **Q.** That is a cultural thing, it hasn't happened and no-one in management says it should.

222. **A.** Unfortunately, that is not my side to do the searching, so I can't say for secure.

223. **Q.** How do you think drugs get in?

224. **A.** Through visitors, and I think there has been some staff in the past. I am not aware of any staff at the present time, I know that we had issues even with Aramark staff in the past as well. I know a couple who have been dismissed due to passes.

225. **Ms Lampard:** When we were here a few weeks ago, just before Christmas, I saw two detainees handing each other something.

226. **A.** Smoking in the whole centre is so prevalent. They are only supposed to smoke in their rooms or in the courtyards. You walk out of Healthcare this morning and I was hit by smoke. It is right next to the gym area where they sit.

227. **Q.** Cigarette smoke?

228. **A.** Cigarette smoke, but occasionally you can smell other substances. You go up to a detainee and say "Put that cigarette out" and they go "Why?" "Because it is not the area to smoke in". They still feel they are in control. They won't listen to you, and officers don't manage it either. It is very difficult for us, because we are the nursing staff, so we can say "Don't smoke", but we can't do the sanctioning. I think they don't have enough things that they can remove from detainees.

229. **Mr Marsden:** There is no leverage.

230. **A.** No, there is no leverage in immigration.

231. **Ms Lampard:** I am being a bit naïve - how do people take new psychoactive substances?

232. **A.** Smoke it generally, but it can come in in various substances. It can come in in almost like a grass, it can come in sprayed on paper, so that is very difficult to see.

233. **Q.** If it is sprayed on paper what do you do with it?

234. **A.** Roll it up around a cigarette and smoke it.

235. **Q.** It is mostly consumed by smoking, is it?

236. **A.** Yes.

237. **Q.** Does it ever come in sort of can you snort it?

238. **A.** No, NPS is usually smoking.

239. **Mr Marsden:** The management of people, how big a job is that for healthcare?

240. **A.** It varies on the strength that they have at the time and what batch is going around. The year before last, in January, the nurses were called to 22 responses in one day, and that is due to people having really psychotic behaviours. A batch a couple of weeks ago was everyone was being sick, so nurses are called. Anybody that we suspect of being under the influences of substance misuse we will move to E Wing, and we will observe them for six hours and do regular observations just to ensure, because there is no treatment for psychoactive substances. We have had a couple that have had to go out to hospital due to respiratory issues, they have come back, and they have smoked again the following day. Even by telling them how severe they were "You went out with an airway in your mouth; you had respiratory arrest", they are still smoking it the following day.

241. **Q.** Do you think that drugs are an issue that G4S could do more to deal with, as in reducing the access to supply?

242. **A.** Yes. The searching of visitors as well, I think, needs to be increased. It has been increased in the last couple of months, probably there has been a lot more passes found in visits, so are they being more vigilant and seeing it? Is that why we have suddenly found it? I don't know whether the security has increased, because I am not in that area, but there has been more passes found in visits.

243. **Q.** Passes?
244. **A.** Passes from a visitor to a detainee.

245. **Q.** Okay, I see what you mean.
246. **A.** I think also the police don't always take much action either, so if people are found with any illegal substances, the police go "It's on your property", so it is difficult. There is no criminal offence. If it was in the community there would be, so why isn't it for being in here?

247. **Q.** The police have an account of that issue. It wouldn't be unfair to say that you think G4S locally could do more on that front in terms of searching, in terms of looking into property.
248. **A.** We had a gentleman today who is in a constant watch room. They did a review yesterday. He is known to have a blade in his mouth, he has a pouch in his mouth that he keeps a blade, and yesterday he refused to give up the blade, but he was then found with a packet of blades at the back of the room. He is on constant watch for self-harming, why has he been given property or blades in his room? That is being investigated. Somebody has given him property which has that not been searched to say "You can't have that".

249. **Q.** What about people who are coming here with alcohol dependency?
250. **A.** We have two substance misuse rooms for anybody that is unstable on arrival, that we use those rooms for, they will be detoxed, they have the medical hatches there, so we can observe those a little more closely at night.

251. **Q.** They are in the CSU?
252. **A.** They are in the E Wing, Rooms 1 and 2 in the E Wing. We have only had those put in in the last year-and-a-half.

253. **Q.** What are your views on the Rule 35 arrangements?
254. **A.** I am on a Panel in London with the faculty regarding future care of Rule 35s and victims of torture. I do think Rule 35s could be completed by a nurse that is trained appropriately. Our waiting time here for Rule 35s is down to two days, because we have extremely good doctors that are working very well with it. It is amazing to be down at that level, but I do find we get an awful lot of requests from solicitors, and even occasionally from Home Office to say "You need to go and get a Rule 35 condition", when actually it doesn't meet the criteria. We get a lot of push-backs, and they want repeats of Rule 35s. It used to be if you have one Rule 35 completed, then that was the answer. Now, if you don't like what was written you can ask for changes to be put into it, if you move to a centre you can get another one written at another centre, but sometimes you have had one response, that torture should be the same no matter where you have been, it is not re-happening, so it is not going to change.

255. **Ms Lampard:** It is the solicitors who are putting pressure on you, on the doctors to change?
256. **A.** They say to the detainee "For you to get released you need Rule 35", so then the detainees come up to us and say "My solicitor told me I have to have a Rule 35", and I had one that they don't do body maps anymore, because the relevance of body maps, a tick in a box, you can't predict where it is. Somebody turned around and said that the doctor put "Scarring could be relevant to a gunshot wound", but it was a gunshot wound. I said "Yes, but

that doctor wasn't there when that gun shot was fired, so he can only put 'could be'". I said "I have a scar on my wrist – you don't know how that occurred, but I have a scar there". It is the relevance of it. The doctor cannot say what happened at the time, just what it might be conducive to.

257. **Q.** What about getting outside? This is in relation to your own doctors; do many of them go and get them from other doctors?
258. **A.** No. No Rule 35s come in from external doctors.

259. **Mr Marsden:** What do Medical Justice do?
260. **A.** They do external reviews, but they don't do the Rule 35 paperwork, so they will come in and do an external review.

261. **Ms Lampard:** It can only be an internal one who does it?
262. **A.** Yes.

263. **Q.** Stephen Shaw in his report says that there is a degree of scepticism in the Home Office about these Rule 35s, and that really they ought to be being done by forensic medical examiners. Is there any sign of moving towards that?
264. **A.** Not at the present time, because there is no funding for that. Where is the training on Rule 35s and torture training? To get any torture training, we are fortunate our doctors here have had it, but torture training provided by NHS and Home Office is so rare, there is very minimal training. It is not a course you can go and ask any GP to go and do, because that is not out there.

265. **Q.** How did your doctors get it?
266. **A.** NHS and Home Office did training last January.

267. **Mr Marsden:** As a one-off?
268. **A.** As a one-off, but as I said, not every doctor in all of the ILCs could attend that day, because we have to continue our care as well. It was a one-off day, but not repeated, and doctors do change. It is then a doctor training another doctor.

269. **Ms Lampard:** Your view of the standard of the Rule 35 reports that you see?
270. **A.** Our doctors are fairly reasonable. We have quite a few that are released due to the Rule 35s, and that has been brought up in Home Office reports that they are surprised at how many are released due to the Rule 35 reports. They think that our reporting is very reasonable.

271. **Q.** Can we move on? I just want to ask about quality issues - CQC.
272. **A.** Yes, I am the CQC Registered Manager for both here and Yarl's Wood.

273. **Q.** When was your last report, your last inspection?
274. **A.** Last inspection was last year in February.

275. **Q.** How did you do?
276. **A.** Reasonable, again. It was on our main issues, I'll just make sure I don't read out the Yarl's Wood one, because that's even more recent. Here it was mental health, care planning - they were our two main issues.

277. **Mr Marsden:** Have you taken steps?

278. **A.** Yes, care plans are looked at and audited regularly now, and mental health, that was increasing our mental health provision and further clinics. They have started doing the coffee/chat groups and more talking therapies.

279. **Ms Lampard:** Clinical governance generally - do you have a clinical governance review? How do you do it?
280. **A.** Yes. We have recently started doing an internal governance meeting monthly with our staff on the floor. We start at ground level. Then I have a quality meeting quarterly.

281. **Q.** With all your staff?
282. **A.** No, that will be with commissioners, with all our providers, and they come to the quality meeting. I have to send all my quality and my governance minutes through to our Head of Governance for G4S as well, and our regional clinical manager.

283. **Mr Marsden:** I presume you have some KPIs to report on?
284. **A.** We don't have KPIs, it is the HJIPs that we report to.

285. **Ms Lampard:** The sort of things you are monitoring are things like timeliness.
286. **A.** How many clinics run, how many vaccinations we have given.

287. **Q.** Blood pressure monitoring, all the stuff we would recognise in the community as clinical governance indictors?
288. **A.** Yes, QAF requirements, which is diabetes, asthma.

289. **Q.** Returns for treatment and that sort of thing.
290. **A.** Yes, things like that we don't get as many. We get a lot more DNAs unfortunately than we do in the community due to they are either in legal visits or they have left the centre. We won't cancel hospital appointments if they have been released into the community because they still have a right to go to that appointment. We will only cancel that appointment if they have flown out of the country.

291. **Q.** There is one particular issue that has been raised with us, and then I will let Ed take over, but when people arrive with medication, that gets taken off them.
292. **A.** Not always.

293. **Q.** Okay, so tell us about when they get their medicines in possession, when they are allowed their medicines in possession?
294. **A.** On arrival they are risk-assessed with an inpatient risk assessment and they will look to see, one, what the medication is; two, if they have had any self-harm issues in the past; three, do they know how to take their medication? It is looking at all the background of it. If that medication is labelled with their names on, it has instructions, it is in a box, and their risk assessment is that they are suitable to have it in possession, then that can be given back to them for them to continue their care.

295. **Mr Marsden:** If someone, say, came in on statins, had been taking them for 10 years, then there was a box of tablets, what would -?
296. **A.** Statins they could have in their possession if they were not at risk of self-harm. They have to sign an "In possession risk assessment" as well, so they are signing to say they will keep it in a safe place, they will keep it locked

away, they will not take it out of the box, they will not share it with others. We do random spot checks on people to see that they are ensuring that they are complying.

297. **Ms Lampard:** Do you have cases where you think you have given somebody medicines and you think they might be being bullied into sharing them/giving them to other people?

298. **A.** If we find that there has been an incompliance, or medication that has less numbers than there should be, we could bring that back into dose-by-dose medication, so we can actually observe it. They are not always happy that they have to come up to Healthcare for dose-by-dose, but we say "It is a review. You signed to say that you would be compliant, and that has not been followed".

299. **Q.** It was raised with us that some of the detainees feel that there is a breach of trust in the sense they come in with their medication, it does get taken off them. Then they have to wait to have it re-prescribed, and then they have also got to have it handed over to them. Is that what the process would be, or would you sometimes keep their medication and just carry on with it?

300. **A.** We could keep their medication, but sometimes it is handed back at the doctor's review, sometimes they come in with aliases as well, so often they have a different name on that medication, we are not going to give that to that person, because we have no guarantee that it is their medication. We need to just do those thorough checks as well.

301. **Mr Marsden:** If someone came into reception and was on a medication that shouldn't be interrupted, as in you need it continuously –

302. **A.** We do have doctors on call that if we don't have a doctor on site and we need that medication prescribed, we have a doctor on call that we can phone.

303. **Q.** What I am asking is if you do take it away from them –

304. **A.** Then we issue it to them.

305. **Q.** It doesn't mean –

306. **A.** They are not going to get it.

307. **Q.** Their treatment gets interrupted.

308. **A.** No. They would be told where to get it. If they are on E Wing we take medication to E Wing, because they are not allowed out. We take medication to them from that. A lot do want medications in possession for things like codeine, and we won't keep codeine in possession because of the tradeable value. As much as their risk assessment may say that they are suitable for them to have it in possession, it is the medication that they can't have rather than them being at risk – it is the medication that is the risk. I have a complaint at the moment, somebody is saying "I should have it in possession. You are stopping my care". I am not, "We have told you where to come, you have been risk assessed, but it is the medication that is at risk".

309. **Q.** Is that because it is codeine?

310. **A.** Yes, it is a codeine-based medication, and he wants it to be, so he will not be giving it.

311. **Q.** It has a value?

312. **A.** A tradeable value.

313. **Ms Lampard:** There was just one last question. We are getting to the bottom of these trust issues which people like to raise with you – there are two sides always of these things. The other one, of course, is the suggestion that has made, we know that, we have seen it in Yarl's Wood, this is the "paracetamol culture", "All anybody does is give me paracetamol", and there are ways of looking at that. If you are in an immigration removal centre you have not much else to do, your mind is quite concentrated on your medical issues. Just talk me round the subject of why people say there is a paracetamol culture.

314. **A.** We try and start paracetamol at a lower level, that is your first level, then if we do need to increase care we have plenty of treatment plans to go up from paracetamol. Paracetamol has many roles and it does work. A lot of people will come to us with headaches, it can be stress-related. When somebody presents "I have continual headaches" it is trying to find out what the background is, but your first port of call will be "Have you taken any treatment for it? Have you taken paracetamol?" It is available on the wings, paracetamol, to be issued by officers, but we look at that log every 24 hours and record it onto the system, so we can see how often they are taking it as well. Many of them will say "I have been taking paracetamol", we look at the log and they have only taken one in the last 48 hours, or one one day and one the next. If you take it four-hourly you are going to get far better control, and it will help.

315. Quite a lot of the foreign cultures they get antibiotics straightaway, and they get injections or suppositories, again, they have to unfortunately learn that the NHS follow NICE guidelines – it is not NICE guidelines to give antibiotics straightaway and it is advising that. We have put out a few leaflets recently about flu and colds and coughs and the use of paracetamol, because that is the 'in' thing at the present time, but paracetamol is a very valuable drug.

316. **Mr Marsden:** Can I just talk about two issue? One is ?Jo Buss, and then go back to just ask you about your involvement in force and charters. Tell us about Jo Buss and the *Panorama* – what you saw, what was going on, what happened, who she was?

317. **A.** Jo Buss, when I first started in 2004 she was my line manager, working at Tinsley House. She then left and returned as a senior nurse at Tinsley House. She worked predominantly at Tinsley House, but obviously at the time of the *Panorama* programme Tinsley House was shut, so all the letting staff had moved up to Brook House to work.

318. **Q.** She reported to you?

319. **A.** She did. She was a senior nurse at that time, and she was then Clinical Lead. She became Clinical Lead for Tinsley House – it was April/May last year. She has excellent one-to-one care and is very passionate about her work. I have known her for many years and I think she wants to do the best she can for the detainees. She sometimes gets too involved and gets too deep into it, and that is her own fault. She shares a lot with officers, which with medical and confidence, you still have to keep that boundary.

320. Regarding the incident, I saw the programme, I wasn't aware of it beforehand. I suspended her prior to the programme. I had been given the phone calls and I was the one that suspended her, I said "Was she actually in the room when the incident was happening, or was she watching from outside, hence she wouldn't be able to write anything?" I have since found out that she was

in the room, but that wasn't shown in the programme, and I am shocked that she didn't report anything, because she is usually somebody that would stand up and say. Shocked and disappointed.

321. **Ms Lampard:** Some of the things we saw on *Panorama* –
322. **A.** Were shocking.

323. **Q.** Do you have a sense, as you and your staff go around, about the nature of the relationship between detainees and officers? What is your overall impression of that sort of relationship?
324. **A.** Generally, I think it is good. I think in every large organisation you are always going to have one or two people that are going to pull it down. Generally, I do think there has been a very good rapport with detainees.

325. **Q.** Do you think that some of the issues that the organisation has had over the last year which we know about, really pretty poor staffing levels, and we also know about pretty poor relations between managers, senior managers, and we know about pretty poor relations between senior managers and staff. We know about front-line managers -?
326. **A.** The one thing I will say to my staff is, whatever I ask them to do, I would do myself. When anything does get really busy, I am the first one to be out on that floor supporting them, because I want them to know that they have got that support. For Healthcare we are a lot closer environment, so it is a lot easier for us to see in to do that.

327. **Q.** Going back to the centre generally, there have been management issues, and do you think that has played a part in relationships? Do you think that has left officers more stressed?
328. **A.** Yes, there has been a big divide.

329. **Q.** Do you think it has left officers more stressed and therefore more likely to behave inappropriately?
330. **A.** I do. I think they felt that they are not worthy in their role – they are not supported in any way. A simple thing for us this year for Healthcare is I have our MD coming down in a couple of weeks, but none of our nursing staff got a "Happy Christmas" from any of the senior management team.

331. **Mr Marsden:** Is that Jerry?
332. **A.** No, that will be Tom Tuppen for healthcare, he is coming to do a visit here on 31st, and it is just feedback that it has been a tough year – just an email saying "Happy Christmas and thank you for your support". It is a simple fix.

333. **Ms Lampard:** Who would you have liked that to come from?
334. **A.** From senior management – Tom Tuppen and by Dorothy Messing. I sent out an email to all my staff, it was just a "I am really grateful for everything you do; keep up the good work". It just makes them feel a bit more worthy.

335. **Q.** Can I just press you a little bit? Do you think that the behaviours over the last period, i.e. in the run-up to *Panorama*, might have been worse because of what we know as well of what was happening in the last period?
336. **A.** Some, yes. It is difficult for me, because I was on that senior management level as well, so I did get the interaction, whereas some of the nursing staff probably didn't know, though we have recently started that governance meeting, so we are feeding down – we have realised, and this has come from

our Head of Governance, that a lot of information is just fed to the top levels but not fed down as well. We have to feed it to all staff so that they know from the bottom and they understand.

337. **Q.** My questions were not so much about Healthcare staff but about the DCOs. I am just trying to find out whether the *Panorama* behaviours were a bit of a blip as a result of a bad period, or whether you think, frankly, that would always have been a possibility that those sort of behaviours were going on?

338. **A.** I think for one or two of the officers that were involved in the *Panorama* programme, no matter what management you have, it wouldn't have changed.

339. **Mr Marsden:** They were pre-disposed to behave that way?

340. **A.** Yes.

341. **Q.** They were, for want of a better word "rotten apples"?

342. **A.** Yes, exactly. They were the ones that you are never going to change. That is part of the recruitment strategy you need to look at. I have had people that I have turned down in posts many years ago, but they came in and we ask about attitudes as well within our interview questions, and they went "They don't deserve to be here anyway". "You are not going to get the job".

343. **Q.** You mean detainees?

344. **A.** Yes. Just certain comments, if they have a derogatory comment in their interview, then that is part of me saying "I have a barrier already, I am not going to do that risk". We always have a few of us, two minimum interviewing. If one has a doubt then we generally say "No", because even if we can't pinpoint that doubt, there is a reason.

345. **Ms Lampard:** Do you think there were more people wandering around this centre as DCOs?

346. **A.** We have a very young lot of DCOs at the moment as well, very young and inexperienced and haven't had the support from seniors.

347. **Q.** That adds to the risk?

348. **A.** Definitely. When we first opened here in 2009, soon after that we had the riot on A Wing, and they then had to get the prison officers down to come and support, to get control back. I do think at times it has been the detainees have been management, not the officers.

349. **Q.** Yes, calling the shots. Your sense of the safety of the place at the moment; if one is safe and 10 is on the edge, where do you think it is at the moment?

350. **A.** It does vary day-to-day, but on average I would say six to seven. We have a higher lot of foreign national prisoners in, and they do take control a lot more. The attitude of detainees, we don't get respect any more. We do get a lot more abuse.

351. **Ms Lampard:** Have your staff been assaulted?

352. **A.** Verbally, daily. We write SIRs as well. I have had one or two that have been physically - one was sexual. The support, again, was not fantastic back.

353. **Mr Marsden:** This is recent?

354. **A.** Yes.

355. **Q.** As in the last few months?
356. **A.** Yes, the sexual abuse was whilst Tinsley was shut, and we had one of the Tinsley nurses up here, so it would have been early last year.

357. **Q.** In terms of visibility of senior management around the centre, if you are out and about, as I would imagine you probably are, what is the visibility?
358. **A.** You see the DCMs, you don't see much of the higher management.

359. **Q.** Steve, or Lee?
360. **A.** Lee, I don't see as much of. Steve does try to go around once a day, but you couldn't always tell – tomorrow we have a Minister coming, so they have gone around and made sure that everything is ready, and it is all prepared, but that is not a true picture. It is like inspections to me, HMIP turn up, I am ready at all times, because that is how I need to be. CQC turn up, come in, it is not a mad panic, because I am ready for them.

361. **Q.** You are trying to run the place like they would expect you to.
362. **A.** Exactly, because I should be running it as a daily thing, not as just on that one week when they are doing the interviewing.

363. **Ms Lampard:** Tell me about the HMIP inspections.
364. **A.** I did the joint one for HMIP and CQC – they come in at the same time. We are seeing more by CQC than we are by the HMIP.

365. **Q.** What is your impression of how people respond here to an HMIP?
366. **A.** Major panic the week before. Major panic.

367. **Q.** Do you think it doesn't really represent the way the centre is when HMIP are there?
368. **A.** No, because they literally go out, they get pictures put up, they make it all look nice, extra cleaning put in, and it is not the day-to-day running.

369. **Q.** That's interesting.

370. **Mr Marsden:** Gaming the system?
371. **A.** Yes. HMIP arrive, and they say "We are unannounced arrivals", but they do their interviews that first week. In that first week there is major work going on behind the scenes and 24-hours a day.

372. **Ms Lampard:** Do you think the response is different in your different centres? For instance, do you think the response is different at Yarl's Wood? Is that how they all respond to it?
373. **A.** They all respond.

374. **Q.** It is very interesting how do you really get the temperature?
375. **A.** Even spot checks in-between. Somebody just comes in "I am just coming for a little spot check today on this subject" rather than do a whole inspection. Maybe in-between the whole inspections there were just spot checks at different sites on different things, because you would then come in and not have to get that pre-warning. Even that week of them doing the interviews –

376. **Mr Marsden:** It is quite orchestrated as well. You are saying "Go in and pick off a subject and just see how it is", coming in unannounced.

377. **Ms Lampard:** Our process is about just boring everybody into submission, just hanging around long enough that somebody – you do get the chance for people to get to know you and let off steam.

378. **A.** I have started the nurses to do a weekly open and chat session for a lunch. The nurses aren't coming in, and I am trying any way to get them to be more open. We are trying to do it an informal way.

379. **Q.** Do you survey them?

380. **A.** They are surveyed, again, that goes out to the main G4S, it is the national G4S' main survey to all of G4S.

381. **Q.** Health staff?

382. **A.** Health and DCOs. That was done the end of last year. Again, I don't think you get great feedback. A lot will say "What is the point of completing a survey because there won't be any changes?" My response to that is "Don't tell us we can't do it, we can't change things".

383. **Mr Marsden:** It's quite cynical?

384. **A.** Definitely. We have a few staff who have been here for a while, so they think "I am not going to change now".

385. **Ms Lampard:** You think there was a staff survey at the end of 2016?

386. **A.** 2017.

387. **Q.** The one we have just had then was a staff survey?

388. **A.** Yes.

389. **Q.** How often do they do those?

390. **A.** We haven't had one for some time. It should be yearly, but I do believe it had been a couple of years before, because I have had that as one of my actions. "Staff survey outstanding", it was red for a long time.

391. **Mr Marsden:** Can I just go back? We left it before I asked my pharma question, Jo Buss has left?

392. **A.** Yes, she was dismissed following the investigation.

393. **Q.** You didn't carry out those?

394. **A.** No, it was carried out by the Director of Nursing, and in conjunction with Care and Justice; they did a joint investigation. The serious incident that was raised from it for NHS has not been closed yet, because of the ongoing police investigation, so that can't be closed yet.

395. **Ms Lampard:** Just going back again to this issue about taking the temperature, one thing we are conscious of is there are very few opportunities here for DCOs - you run a small team, so you can discuss things with your team, but as a group we see very few opportunities for staff to engage with management about things that affect them, things that they think need to be changed. There is very little give and take on that front, is that your impression?

396. **A.** Yes, and even for nursing staff, staff meetings, if I run a staff meeting, because you have only got so many staff on shift they won't come in on days off. Even we have offered them "We will pay you extra hours for coming in", they won't come in, and I always say at the beginning of the meetings "This is not me just spouting information, it needs to be a two-way communication", but generally it is me spouting information! I am trying to encourage them

"You have an idea, put a plan in and give it to me. It is not going to be disregarded, I want to have a look to see, and it doesn't matter what level you are – whether you are a healthcare assistant or a senior nurse, everybody has a part in the team and a good benefit to the team".

397. **Q.** Of course, you have the advantage that there is clinical supervision now.
398. **A.** Yes, so they are getting that now. That is a one-to-one supervision. I do try, if there are any major incidents, I will do a debrief session as well, and if I see any nurses struggling then I will pull them to the side to try and work with them.

399. **Q.** Thank you.

400. **Mr Marsden:** Can I ask you about your involvement in charters, use of force? I am conscious of time, we will finish in the next 10 minutes or so.
401. **A.** Use of force, if it is a planned use of force we are called beforehand, so if they are going to do use of force on Joe Bloggs we will look up medical records before we go up there to review anything. We are then present throughout the whole of the use of force. We have been asking for a long time for use of force training for nurses' role, that has now been given to nursing staff. That is being issued by Steve Skitt at the present time. That is for any planned ones.

402. **Q.** That is your part?
403. **A.** We are observing, and we are observing the role, as any injuries or the safety of the patient, and we are the people that can say "Hands off". The officers are supposed to jump, as soon as we say "Hands off", obviously they are supposed to be off straightaway. That has been told to nursing staff for many a year, and Jo Buss was fully aware of that as well, that is why I am so shocked that nothing was said, if she was in that room at the time.

404. **Q.** Charters?
405. **A.** For unplanned C&Rs, we are usually called as a first response, and we will then attend. Throughout all of those planned and unplanned ones we have all of our basic life support with us as well, so we can do any treatment if required. For charters we are not involved as much.

406. **Q.** Not by design? You are in it unintentionally.
407. **A.** Not intentionally. People are moved down to the Eden Wing, if they are, we will be taking them on the escorts if they are moving non-compliantly, but charters, we will hand over any medical information to the medic on the charter, but we are not there to see everybody going out.

408. **Q.** Do you think you need to be involved more in charters?
409. **A.** We are involved on the pre-call. There is a pre-call which is with Home Office and everything usually the day before, so we are involved in that. As long as we can get that information to the medic, and we hand over the information, hand over the medical records, hand over the medication, I don't think we need to necessarily stand there for every single person going out. Escorts will still want to open medical records who are not medics.

410. **Q.** They still want to open medical records. Why?
411. **A.** Because they think they need to know what is wrong with the person, even though we have an outer form that says "No medical issues".

412. **Q.** Do they go?
413. **A.** Yes, and it has still been an issue.

414. **Q.** That is TASCOR opening?
415. **A.** Yes, and that has been raised in various audits that have been raised.

416. **Q.** Do G4S senior management know about that?
417. **A.** Yes, and it has been raised through Home Office. Home Office know about it.

418. **Q.** Does your commissioner know?
419. **A.** Yes.

420. **Q.** Are representations made to TASCOR about not doing that?
421. **A.** Yes, and it has been said "Yes, they won't open them". We have done the form on the front that is a separate one to save them opening, which says if they have any medical conditions "Yes/no", anything that they need to know as a public health issue, that would be on there, but they still look at the records. We much prefer to hand it over straight to the medic, but the medical records are actually the property of the detainee for their onward travel. It is supposed to be, so they can hand it to any doctor that they are going onto.

422. **Q.** Do you have any liaison? When somebody is going back to Ghana or Jamaica, do you have any contact with local health services?
423. **A.** Very rarely. Occasionally, if they were on a treatment plan for HIV or anything we would look up the World Health Organisation to see what available in their area that they were going to. Often, we won't know where they are actually going.

424. **Q.** Finally, is there anything you want to tell us that we haven't discussed?
425. **A.** For us, we have changed a lot in G4S Health in the management system as well – lots of management has changed there. Even response from our seniors is very limited now. There has been a bigger gap in information coming from management.

426. **Ms Lampard:** What sort of information would you like from them?
427. **A.** It is the support as well. I said to my managers that I was having this interview today, just so they were aware that I was having this interview. My original clinical manager phoned me this week, but that is the first time I have spoken to her since before Christmas. She is supposed to be my line manager, and she spoke to me the week before Christmas. I don't even have her weekly whereabouts, as to where to get hold of her. Often, she is in prison, so she won't have a phone, but I won't know where she is, so if I needed to get hold of her on an urgent case, I have no way of finding out where she is, so it is a case of phoning around every prison.

428. **Mr Marsden:** Where is she based?
429. **A.** Home based. She could be in Liverpool, she could be in Wales.

430. **Q.** When you are out of here would your team know?
431. **A.** Yes, my staff know, and I have also given them access to my diary, so they know where I am.

432. **Q.** They know you are two days at Yarl's Wood this week?

433. **A.** The other practice managers who practise at Yarl's Wood and here have all access to my diaries and know where I am. I share one diary up as well as down.

434. **Q.** If you could be in our position where you can make recommendations to the Board, are there two or three things that you thought they could say that would make a difference, if we implemented them? What would they be? What are the things that would have real impact?

435. **A.** It is giving recognition to staff. A recommendation that my staff have suggested, they do an Employee of the Month throughout the whole of G4S now. That is such a good group that it is quite rare that any of the staff get it, so they asked for one to be put in locally, so it is just a minimal recognition and that is just a "Thanks, you are doing a good job". They want to see positivity, so they can be positive as well.

436. **Q.** This issue of recognition of people above you, saying "You are there, we recognise you, we are communicating with you", that is quite a big theme.

437. **A.** Yes. For Health that never used to be, it has been since we had a change of management. There have been quite a few changes in G4S Health, and a lot of people have left due to line management.

438. **Q.** Recognition of staff would be one, anything else?

439. **A.** I am just trying to think.

440. **Q.** It's not a test!

441. **A.** I have asked this week for Healthcare to be decorated, for the simple fact that it is looking really drab and I don't think that helps both the detainees and staff. If they are working in a drab environment I don't think that actually helps.

442. **Ms Lampard:** Is that a G4S Healthcare or a G4S Custodial?

443. **A.** Custodial, because they own the building.

444. **Mr Marsden:** That is a Steve/Lee decision.

445. **A.** That is what I have asked them this week. They have come down and said "Yes, it looks dirty". It is, it is dirty, and we are supposed to be healthcare, so we are failing at things like infection control compliance.

446. **Q.** Is the cleaning okay?

447. **A.** No, the cleaning is rubbish. The cleaning is very poor. We are raising it, and that is because they subcontract out. They don't have any clinical cleaners either, as such.

448. **Q.** It is Aramark?

449. **A.** It is Aramark who clean our rooms. They don't know about clinical cleanliness. They are supposed to hoover before they mop, they just mop around, forget the corners, forget ledges.

450. **Ms Lampard:** That is a very important issue.

451. **A.** There are quite a few things on that. We have a crack down the wall that looks really dirty in healthcare. We had a board ripped off by one of the detainees and that has been ripped off for quite a few months now and we still have the mark of the board there.

452. **Q.** What time does our meeting begin, is it 12?

453. **Mr Marsden:** Yes, I think it is.

454. **Ms Lampard:** We have time to go and have a look. Let's have a look.

455. **Mr Marsden:** Shall we turn this off?

456. **Ms Lampard:** Thank you very much indeed.

[*Interview concluded*]