BROOK HOUSE INQUIRY

FIRST WITNESS STATEMENT
OF
PHILIP DOVE

I, **Philip Dove**, Managing Director of G4S FM and Public Services, and Director of G4S Health Services (UK) Limited ('G4S Health'/'the Company'), DPA DPA will say as follows:

INTRODUCTION

1. I am authorised by the Company to make this statement and do so in response to the Inquiry's Rule 9 requests dated 19 July 2021 and 29 October 2021.

2. I have no personal knowledge as to any of the matters identified in the BBC Panorama programme. I also have no first-hand knowledge of the management of healthcare at Brook House between April and August 2017 or about the contractual/commissioning arrangements between the Home Office, G4S and National Health Service England ('NHSE') during this time.

3. I therefore make this statement on the basis of the information provided to me following the commissioning of enquiries and/or review of the Company's documents and records. These enquiries have in certain areas been constrained by a loss of knowledge; none of the senior managers that were involved during the Relevant Period (as defined below) are still employed. Also, all operational members of staff that were employed during the Relevant Period and who continue to work at Brook House are no longer in its employ by reasons of TUPE transfer (explained further later in the statement).

4. Between 1 April 2017 and 31 August 2017 ('the Relevant Period'), the Company's Managing Director was Mr Tom Tuppen. Mr Tuppen left the Company in September

2019. Following Mr Tuppen's departure, the Managing Director was Mr Wayne Felton, who sadly passed away in December 2019. Ms Angie Hill was the Nursing Director. Ms Hill left the Company around November 2018.

5. Ms Sandra Calver held the post as Head of Healthcare at Brook House since 2014 (supported by a Clinical Lead and Senior Nurse), and remained in this position until the contract for healthcare services transferred to Practice Plus Group (formally known as Care UK) when the Company's contract to provide services ended on 31 August 2021. She has however continued to provide assistance with regards to the Rule 9 requests.

6. The healthcare services provided by the G4S Group used to form part of an internal division of G4S Facilities Management (UK) Limited ('FM'), FM providing healthcare at a number of PFI (Private Finance Initiative) prisons.

7. G4S Group also operated healthcare services through G4S Medical and Forensic Services (UK) Limited ('M&F'), which provided medical and forensic services to national police authorities.

8. M&F changed its name in October 2016 to become G4S Health. The Company then took delivery of all healthcare service functions previously performed by FM, essentially bringing all healthcare services under the one roof.

9. The contract for healthcare at Brook House during the Relevant Period commenced on 1 September 2014 and was between NHSE and FM, although as set out above, services were provided by the Company.

10. FM originally took over the healthcare contract in 2011 from Saxonbrook Medical. The service was at that time commissioned directly by the Home Office. However, NHSE took over commissioning responsibility in 2014.

11. Whilst G4S Care and Justice Services (UK) Limited ('CJS') and G4S Health are both entirely separate companies, each operating independently of each other, both form part of the wider G4S Group and there would therefore from time-to-time have been interaction between the companies at a Group level.

12. At a local level i.e., at Brook House, there would be daily management meetings between employees of the two companies (led by CJS).

13. The Company also invited CJS to its governance and partnership meetings; these meetings were also typically attended by the Independent Monitoring Board ('IMB') and the Home Office ('HO'). Likewise, CJS would invite the Company to its security, health and safety & diversity meetings.

THE PANORAMA PROGRAMME

14. This is a corporate statement for the Company. It would not therefore be appropriate to comment or speculate on the causes of behaviours of staff employed by other organisations. It is also difficult for me to comment on the causes of staff behaviour in general terms; the conduct of different staff members will likely have been driven by different factors, causes and considerations. Where appropriate, I comment below in relation to particular staff and events.

15. The programme featured one Healthcare member of staff - Ms Joanne Buss, a Registered Nurse ('RN'). As Ms Buss was not known to me, and I had no role in the day-to-day management of Brook House, I am unable to meaningfully comment or speculate on the causes, or probable causes, of her behaviour.

16. The Company understands that Ms Buss' behaviour was unexpected; there had been no prior concerns or issues around her conduct or professional practice in the past, and as it understands from the former Head of Healthcare, she had a reputation to go above and beyond to help detainees. She was also well thought of by her colleagues.

17. The Company is not aware of any prior complaint about Ms Buss and she had not been subject to any prior disciplinary action. She was however suspended the day after the programme aired, given the serious issues raised by the Panorama programme, and to ensure the health and safety of those in our care.

18. Following the programme, a joint disciplinary team was formed from employees of both G4S Health and CJS to investigate the various staff members featured in the programme. I do however only comment on Ms Buss given that she was the only employee of the Company subject to investigation (as she was the only G4S Health employee implicated in the Panorama programme), upon conclusion of which, she was dismissed for gross misconduct on 28 September 2017. The Investigation Report into her actions has been disclosed to the Inquiry [ref: CJS004337].

19. The HO and Care Quality Commission ('CQC') were notified of the programme and of Ms Buss' involvement. As one would expect, they were not however involved in the internal investigation.

20. On 7 September 2017, the Company filed a Serious Incident ('SI') report with NHSE [ref: CJS0073837]. NHSE opened a serious incident in StEIS (Transfer of Strategic Executive Information System) (STEIS ref 2017/22218), which is their system for recording and monitoring progress of serious incident investigations.

21. Following the SI submission, the Company was required to submit a Root Cause Analysis ('RCA'). The RCA is an NHS led document reporting tool designed to capture serious incidents. Its purpose is to demonstrate good governance and safety and to also demonstrate lessons learned. The report should include any relevant chronology, actions plans and the actions taken against them.

22. The RCA was delayed in view of the then on-going police investigation, which prevented the Company from proceeding. Due to loss of knowledge, and Healthcare's limited role in the police investigation (which was led primarily through CJS), the Company is unable to say when clearance to proceed was given, but following this, Ms Hill was commissioned to conduct the required RCA investigation. However, following her departure from the Company, it was identified that this did not appear to have been done.

23. The investigation was then tasked to the Company's Chief Nurse (Mr Andy Cook) and Associate Director of Governance (Ms Haider Al-Delfi) resulting in the completed RCA being submitted to NHSE on 23 July 2019 [ref: CJS007094].

24. Following submission of the RCA, no further action was taken by NHSE. It is assumed that it was content with the action plan set out in the RCA and the progress made against each of the identified matters. The incident was then closed.

25. It is noted that the RCA was prepared sometime after the incident involving Ms Buss, and appears to have been prepared on the basis of a feedback session [ref: CJS0073838] rather than on more focused investigations. It also appears that the authors may have conflated a number of different and wider custodial issues rather than remaining focused on the specifics of Ms Buss' conduct.

26. The Company cannot comment on the police investigation as it had no involvement in it. This was however limited to potential criminal conduct of CJS staff as opposed to healthcare staff. The investigation was also coordinated through CJS.

27. On 5 September 2017, the day after the programme aired, Mr Tuppen visited Brook House and issued a notice about his concerns about what he had seen on the programme. He also emphasised how all staff had a responsibility to report issues to management and reminded everyone of the Speak Out facility (all staff being handed Speak Out cards - Speak Out being the G4S whistleblowing facility, which is explained in more detail below).

28. With specific regard to Ms Buss. The matters raised in respect of her practice were serious and therefore, in accordance with the Company's standard practice, on 12 September 2017, an Employer Referral was made to her regulating body, the Nursing and Midwifery Council ('NMC'). The Company believes that this was made via the NMC's on-line portal. Following receipt of which, they issued an interim suspension order pending its own investigation. This meant that Ms Buss was unable to practice as a nurse. She would was in any event unable to practice for the Company following her suspension.

29. The NMC investigation concluded on 23 February 2021 with Ms Buss being removed from the register of nurses (having already been dismissed from the Company by this time) [ref: CJS0073840]. Like the HO and the CQC as referred to above, the NMC had no involvement in the disciplinary investigation. Nor did the Company have any involvement in the NMC investigation (there was no other regulator involved in the matter) save that Ms Calver provided a Witness Statement to the NMC on 15 March 2019 [ref CJS0073842] and another on 21 June 2019 [ref: CJS0073841]. She was due to give evidence at the Substantive Hearing, but this proved unnecessary as Ms Buss accepted the charges against her and agreed to be removed from the register.

30. The Company has been asked to address any lessons learned following the disciplinary investigations, and how, if at all, these were carried forward into practice. In respect of the Company, there was only one investigation, that being into the conduct of Ms Buss as already addressed. The Company is unable to address the question further given my lack of personal knowledge and the fact that the relevant managers involved during the Relevant Period are no longer in its employ. Although not as a direct result of the outcome of Ms Buss' investigation, a number of changes were implemented by the Company following Panorama, which are explained later in this statement including but not limited to, the RCA recommendations. These documents detail the progress made in relation to those recommendations. Similarly, the briefing note also details various other steps that had been taken [ref: CJS0073838].

31. The issues identified in relation to Ms Buss were in connection with her personal conduct, not systems or policy failures. Nor, to the best of the Company's knowledge and belief were there any issues raised that extended to potential wider issues concerning the Company's employees.

STAFFING AT BROOK HOUSE DURING THE RELEVANT PERIOD

32. The staffing levels within healthcare were managed across all three Gatwick IRC sites i.e., Brook, Tinsley and Cedars (although this site closed in December 2016). It is not therefore possible for the Company to provide data specifically for Brook House. The

Company has however disclosed to the Inquiry 'Staffing Figures' [ref:CJS007018]. This document provides a full breakdown of all job roles, number of positions and number of vacancies during the Relevant Period.

33. RN's were formally known as Registered General Nurses ('RGN') and are therefore referred to as such within this document.

34. The document does not show GP roles as these were sub-contracted by the Company to Doctor PA Limited ('Doctor PA'). They were responsible for ensuring that all roles were covered, which they were i.e. 1 GP on site at Brook House each day.

35. The document does not show psychiatry or psychology roles. The Company did not provide secondary healthcare services. These were subject to separate commissioning arrangements by NHSE, and these practitioners would attend Brook House as and when required.

36. In respect of the roles provided by the Company. Notwithstanding the number of vacancies, the Company understands from its former Head of Healthcare that all shifts were fully staffed during the relevant period through a combination of the use of bank staff, agency staff, and overtime and/or cross-utilisation. By cross-utilisation, I mean that occasionally, RNs would provide cover for vacant Healthcare Assistant shifts through overtime.

37. There was no dentist service on site.

38. Staff utilisation was as follows:

	Rostered	Overtime	Bank	Agency	Total
April	183	4	14	0	201
%	91%	2%	7%	0%	
May	181	3	6	8	198
%	91%	2%	3%	4%	

June	139	13	8	49	209
%	67%	6%	4%	23%	
July	102	20	14	64	200
%	51%	10%	7%	32%	
August	125	15	10	74	224
%	56%	7%	4%	33%	
Total	730	55	52	195	1032
%	71%	5%	5%	19%	

39. The numbers set out in the table above represent the numbers of shift covered. The percentages represent the numbers of staff in that requisite area that were used to cover the required shifts in that month. For example, there were 201 shifts in April. 91% of these were covered by rostered staff, 2% by overtime and 7% by bank staff.

40. As above, all shifts during the Relevant Period were covered, as set out above. The staff rotas for the Relevant Period have also been disclosed to the Inquiry:
    - April 2017 - CJS004074
    - May 2017 - CJS004073
    - June 2017 - CJS004075
    - July 2017 - CJS004076
    - August 2017 - CJS004077

41. Recruitment was a priority for the Company. Vacancy positions were live for all roles across a number of platforms, including the G4S careers website, NHS Jobs, Monster and Indeed websites. Recruitment agencies were also utilised and the Company ran a local jobs fair in April 2017.

42. Recruitment continued to be a priority for the Company after the Panorama programme aired and it continued to use the same recruitment channels as outlined above. However, the programme led to a couple of nurses pulling-out of the recruitment process.

43. The Company does not consider that the staffing levels in Healthcare during the Relevant Period played a role in the mistreatment of detainees.

44. The Company does not consider that the staffing turnover in Healthcare during the Relevant Period played a role in the mistreatment of detainees.

45. The Company does not consider that the use of agency staff in healthcare during the Relevant Period played a role in the mistreatment of detainees; many such staff had worked for the Company for several years.

INDUCTION

46. All new starts were provided with an induction pack and required to complete a 4-week induction. This included working alongside all disciplines i.e. RN, RMC and Pharmacy. They worked a wide range of shifts to enable them to understand and see how the various clinics ran. They worked both day and night shifts across Brook and Tinsley House.

47. The Company believes that the induction process was comprehensive and properly prepared staff for their roles within Brook House. As far as the Company is aware, no issues or concerns had been raised by staff about any issues or deficiencies with the induction process.

TRAINING OF G4S HEALTH SERVICES STAFF

48. Use of Force / Control and Restraint ('C&R') training was provided by CJS to CJS custody staff. Use of Force and C&R could only be performed by certified DCOs and DCMs. Such training was not therefore required, or given, to healthcare staff. Accordingly, it was not part of the Company's initial staff or refresher training. Notwithstanding, healthcare staff did sometimes attend C&R training sessions, in an educational, observational capacity only.

49. Non-operational staff, including healthcare staff, received personal protective training. This focused on de-escalation and breakaway techniques rather than use of force. This training was refreshed every three years.

50. The process followed in relation to the production of reports pursuant to Rule 35 of the Detention Centre Rules 2001 is set out in Detention Service Order 06/2016, issued by the HO [ref: CJS007075]. Not all incidents of self-harm would result in the production of a report under Rule 35(2), as this deals with suicide.

51. Some detainees would engage in self-harm in an attempt to prevent deportation rather than through genuine suicidal ideation. It equally follows that there would not necessarily be a Rule 35 report where detainees were subject to an open ACDT (Assessment Care in Detention and Teamwork), which would be initiated by the examining doctor.

52. Whilst awaiting Rule 35 training from the HO, in 2016, Nurse Buss designed a PowerPoint presentation for nursing staff to provide an understanding of the Rule 35 process [ref: 011121-HCWS-0013].

53. In 2018, the Company reviewed the Rule 35(2) process and developed a pathway [ref: CJS0073839]. I believe it was devised by the local healthcare team lead by Ms Calver to set out the steps to be followed for reporting under Rule 35(2). I also believe that a copy was shared with all the GPs and a copy attached to the notice board in the doctors' office. Healthcare staff were made aware of it at a staff quarterly meeting. I am unaware of any specific training on this document of the process.

54. I understand that a copy of the document was shared with the commissioning authority (NHSE) and the HO. As a healthcare document, I do not believe that it was shared with detention custody staff.

55. Whilst general awareness training was provided to some staff in relation to Rule 35, such reports could only be submitted by GPs. The Company did not directly provide GP services. As above, these were sub-contracted to Doctor PA.

56. The Company has never engaged in the direct provision of GP services, which is why this element was sub-contracted. The contract was awarded to Doctor PA following a successful tender and was reviewed by the Company's Medical Director. There were also regular contractor meetings between healthcare and Doctor PA whereby any issues were discussed and resolved. Any significant performance issues or complaints concerning GPs were referred to the Company's Medical Director.

57. As far as the Company is aware, there were no serious performance issues or complaints concerning Doctor PA during the Relevant Period.

58. The Company has disclosed to the Inquiry records in relation to mandatory training ref: CJS007027 and ref: CJS007028. See also CJS007026, CJS007031 and CJS007034.

59. On joining, all staff received an Induction Pack [ref: CJS007026], which contained the mandatory policies. They were also required to attend a Health and Safety Induction. Additionally, they were required to attend key and radio training provided by CJS.

60. Mandatory training included Levels 1, 2 and 3 Safeguarding, Equality and Diversity and mental health training.

61. The Company has been asked to comment on the training that staff received in relation to the management of detainee's welfare. With specific regard for G4S Health staff, whilst there was no training modules specifically for detainee welfare, welfare concerns underpinned and drove the mandatory training courses in safeguarding and mental health. All staff were also required to undergo refresher equality and diversity training every 3 years. Prevent training also went on-line in 2017, which related to the prevention of terrorism and radicalisation.

62. Minimising and Managing Physical Restraint ('MMPR') relates to children and is not therefore relevant to Healthcare staff at Brook House.

63. The first Adults at Risk Training was provided by HO on 29 October 2018.

64. Training in the management of individuals with substance misuse was not mandatory. However, all GPs prescribing withdrawal/detox medication would be RCGP (Royal College of General Practitioners) level 2 trained in substance misuse. A few nurses and the Head of Healthcare had undertaken the level 1 course in 2016.

65. During the Relevant Period, initial ACDT training was provided to Donna Batchelor on 13 April 2017 and Nicola Wells on 12 May 2017. Yearly refresher training was provided as follows:

- Anne Herbert – 14 June 2017
- Daliah Dowd – 24 May 2017
- Havva Daines – 10 May 2017
- James Newlands – 10 May 2017
- June Watts – 10 May 2017
- Mariola Makucka – 10 May 2017
- Pamela Neal – 10 May 2017
- Ray Little – 10 May 2017
- Stanislava Fedicova – 14 June 2017
- Wendy Linvingstone – 14 June 2017

66. Staff training details are set out in more detail in the staffing matrix disclosed to the Inquiry [ref: CJS007028]. This training was not required for the practice manager or administration staff.

67. The Company does not believe that inadequacy in the training of staff i.e., those of the Company, were a factor in the mistreatment of detainees.

MANAGEMENT OF BROOK HOUSE

68. The structural organisation chart of the Company during the Relevant Period has been disclosed to the Inquiry [ref: CJS005916].

69. Clinical supervision was generally undertaken in the form of 1-1 sessions with the Senior Nurse or Clinical Lead. Any particular issues or problems would have been discussed within the group during shift handovers. A debrief session would also have followed after any serious incident.

70. Neither the Company, nor (as far as it is aware) its senior managers, were aware of any of the issues raised in the Panorama programme. They would otherwise have taken immediate remedial action. As far as the Company is also aware, there was no indication to suggest that senior managers should have been aware of such events, particularly those in relation to Ms Buss. The majority of the issues raised in Panorama related to the treatment by custody staff.

71. Healthcare staff were not located on the residential wings (only attending to specific circumstances, such as visiting detainees in their room if they were unable to attend healthcare in person, or in respect of a planned use of force event). Staff therefore had limited opportunity to observe interactions with detainees and custody staff on those wings.

72. As far as the Company is also aware, there was nothing in the detainee complaint history to indicate the happening of abuses. Nor were any concerns raised by any of the other multiple organisations that regularly attended Brook House.

73. As to the steps taken following the Panorama programme to ensure managers were in a position to identify and prevent mistreatment of detainees, all Heads of Healthcare were given additional training in the form of safeguarding level 4. Staff were also encouraged to watch any camera footage of use of force incidents.

74. The Company also amended its recruitment practices following the Panorama programme. The Company conducted competency-based interviews for all staff. The questions asked were updated after Panorama to include specific examples of where

staff had in the past witnessed unsafe or inappropriate practice or procedure and what action they took in relation thereto. Other additional questions included asking about what lessons had been learned from past incidents etc. The reasons for this was because we wanted to recruit staff who treated detainees appropriately and to ensure that if they witnessed any inappropriate conduct, they would intervene and/or report it to the appropriate persons.

75. The Company does not believe that there were any management failings within Healthcare which were a factor in the incidents shown in the Panorama programme.

HEALTHCARE FACILITIES

76. A map of the Healthcare layout has been disclosed to the Inquiry under reference number [ref: CJS007017]. A description of the environment has also been disclosed [ref: CJS0074049].

77. The main clinic room had chairs, an examination couch, ECG machine, phlebotomy equipment, dressing cupboards, dressing trolley, privacy screen, examination light, telephony for translation services, computer and medical records access and an oxygen cylinder.

78. The doctors' consulting room had an examination couch, examination light, table & chairs, computer and medical records access, privacy screen, an oxygen cylinder and telephony for translation services.

79. The pharmacy room had secure cabinets for medication and controlled drugs. The main door was secured behind a metal gate and had a drop hatch box to allow administration directly to detainees.

80. There were also two additional rooms located in the reception area used for various purposes. These rooms were equipped with table and chairs, computer and medical records access, privacy screen and telephony access. One of the rooms also had an examination couch.

81. The mental health room had a table and chairs, sofa, telephony, computer and medical records access.

82. Healthcare did not have a dental suite. It otherwise had all the resources available to deal with the routine healthcare needs of the detainees.

ACCESS TO HEALTHCARE

83. There was an open triage clinic operated every morning between 9.30am and 11.30am. Detainees were free to 'walk-in' without an appointment to see a nurse. GP appointments would then be booked when appropriate. This clinic enabled detainees to access both primary care (physical health) and mental health services.

84. Triage appointments could also have been requested directly by detainees via a post box on the residential wings. Healthcare would respond to such requests by issuing appointment slots.

85. If a detainee required medical assistance whilst locked in their room, they would use the in-room call bell to communicate with officers. They would then notify Healthcare, and a nurse would attend the detainee in their room. Nursing staff did not have keys, so would be escorted from Healthcare by CJS officers, who would be required to open doors and gates.

86. As far as the Company is aware, there had never been any incident of officers refusing Healthcare staff access to detainees or to unlock access doors or gates.

87. Pursuant to Rule 34, all new arrivals should have been given a GP appointment within 24 hours (unless refused). GP appointments were otherwise arranged through triage as outlined above. GPs would also attend to detainees in their room if for any reason they were unable to attend Healthcare (because for example if they had been removed from association). There were also two GP embargo slots every day to allow GPs to attend to any emergencies.

88. Mental health services were accessed in the same way as in the community i.e., through a nursing or GP referral. Detainees could also self-refer. An appointment would then be arranged with a psychiatrist. Any required follow-on treatment would be arranged by the psychiatrist as appropriate.

89. Dental issues were triaged by nursing staff in the usual manner with detainees placed onto the waiting list for the visiting dentist. Emergency dental cases were referred to the out of hours emergency service, which usually resulted in a same-day appointment.

90. Detainees arriving with medication would usually continue to use this medication, providing that it was labelled in their name and the prescription details legible. If there were problems with the medication that detainees had with them, not being properly labelled for example, it would be re-prescribed, which may cause a slight delay Detainees requiring continued medication would be subject to a risk assessment to determine whether they could keep their medication in their possession. Medication would otherwise be dispensed from the pharmacy drop-hatch three times daily (8.30am to 9.15am, 1.30pm to 2.15pm and 7.45pm to 8.15pm).

91. Any medication issues would be referred to the GP at the next clinic or if urgent or out of hours, by contacting the on-call GP.

QUALITY CONTROL

92. There was in operation a Quality Committee. The committee met quarterly and intended to ensure that the healthcare services were being delivered to a high quality. The meetings would typically be attended by the Head of Healthcare, the Practice Manager, Pharmacist, relevant mental health/drug and substance misuse staff. Also represented would be the GP provider, the HO, IMB and NHSE.

93. A Quarterly Meeting was held on 11 April 2017. A copy of the minutes has been disclosed to the Inquiry as requested [ref: CJS0073826], as is the PowerPoint presentation delivered at that meeting [ref: CJS0073830].

94. Actions were worked on between meetings and closed when completed. The necessary actions plans (and owners) would be listed in the requisite meetings, which would be reviewed at the next meeting, as demonstrated in the minutes for the meeting on 11 April 2017.

95. The Health Improvement Plan was the location for all active action plans, with a tab for closed actions. Actions would cover many areas and be created from recent health improvement plans, CQC visits, infection control audits, IMB reports etc. Healthcare would devise a set of next steps to be taken and share at the next Quality Committee meeting to see what progress had been made and what still needed to be done, if anything.

96. Who worked on the actions depended on what the particular action was. The relevant parties would be given tasks to work on in order to meet the required action. The action would be closed off when staff were in agreement that it had been satisfied and there were no further steps to take.

97. It is noted from the Quarterly Meeting held on 31 October 2017 [ref CJS0000527] that not all new staff had awareness of C&R and the role of a nurse (in the context of C&R). This is training that was to be provided by CJS, but following actions taken by CJS in direct response to the Panorama programme, they were several instructors down. CJS tried to provide temporary replacement instructors from other CJS sites. However, as set out earlier, healthcare staff were not required to be C&R trained, but attended sessions in an observational capacity. To remedy the issues raised by staff, the Deputy Director (of Brook House) joined some staff meetings to address and give advice to nurses on their role in relation to C&R.

98. The Company has been asked to comment on the incidents recorded in the minutes of the Quarterly Meeting of 31 October 2017. I understand that the Inquiry is referring to the incident summaries in Section 7. Without details of the individuals involved, it is not possible for the Company to state with any certainty what specific actions were taken as the incidents cannot be tied to any specific patient records. There is no other information contained within the document to allow the Company to reverse identify the specific incidents which would allow further investigation. However, as with any cases of the types mentioned, the detainees would have received appropriate first aid treatment.

99. Those detainees concerned with self-harm would have been followed up by the mental health team.

100. The Company has also been asked to comment on the lessons learned as a result of the complaints made and documented in the said minutes dated 31 October 2017, in particular, where the lessons learned related to 'respect for detainees - related to staff attitude'.

101. On the matter of complaints. All complaints were investigated and responded to. I note that the minutes document that none of the complaints were upheld and that all relevant complaints have been disclosed to the Inquiry. Given my lack of knowledge and the fact that those engaged in the provision of the services during the Relevant Period are no longer employed by the Company, the Company is unable to answer further in relation to lessons learned.

102. With regard to the treating of detainees with respect and staff attitudes. The Company understands that this was addressed further in a staff meeting held on 2 November 2017 [ref: CJS004286].

103. There was at that time an increase in the use of NPS (New Psychoactive Substance) amongst detainees. This was a significant problem across the entire secure estate, not just at Brook House. Due to the increase in related incidents, Healthcare was reprofiled to include a paramedic, who started in August 2017. This allowed for more

detainees to be treated on-site, without having to go to hospital. This also assisted management in achieving positive outcomes in the case of two respiratory arrests that occurred in that quarter.

104. All local policies were reviewed following Panorama and changed as appropriate through the Clinical Policy Committee, which was led by the SMT. Local SOPS that were changed include those that related to the dispensing of medication outside of pharmacy (October 2017), Emergency Response (March 2018), mandatory healthcare debrief (May 2018) and Admission screening sign-off (June 2018). The Company however understands that these changes were simply to bring them up to date and that no changes were specifically required in relation to matters following Panorama.

105. The Company has been asked to set out what the result was and what action was taken as a result of the Care Plan Audit recorded in the minutes of the meeting held on 31 October 2017 as being in progress. However, due to loss of knowledge, the Company is unable to do so.

106. The Company has been asked to set out the 14 risks recorded as being registered on the Quality Risk Register and the actions taken as a result. This information is however set out in the Register [ref: CJS0073828]. This also documents the necessary further actions, issue owners and an update on the progress again each risk.

OVERSIGHT

107. The HMIP Service Improvement Plan 2017 ('HMIP Plan') recommended that a health needs assessment should be carried out and a centre health and wellbeing strategy should be developed. The recommendation for the health needs assessment however fell to the commissioning Authority, NHSE. The Company understands NHSE did conduct such an assessment in early 2018, although for want of knowledge, it is unable to provide further information.

108. A centre health and wellbeing strategy was developed by CJS, with input from the Company.

109. The HMIP Plan recommended that there should be regular clinical audits. The Company did carry out regular clinical auditing including of SystmOne records (this is the primary care patient record platform used across the NHS), safeguarding, medication, infection/prevention control, complaints and care plans [ref: CJS0073843 to CJS0073854].

110. The HMIP Plan recommended that detainees with no, or little grasp of English should have reasonable access to translated information about the healthcare services. A number of foreign language leaflets were drafted and placed in the Healthcare reception. Copies were also placed in the library. A schedule of the translated leaflets has been disclosed to the Inquiry [ref: CJS0073827].

111. Healthcare had access to translator services from Big Word and Language Line. Detainees requiring information in a language for which there was no translated leaflet, they would be put in touch with a translator. This would happen sometime even when there was a leaflet available, as this would only answer set questions whereas the translator would be able to answer more specific and/or additional questions. Common languages were sometimes spoken by nursing staff, so they would occasionally be called upon to assist.

112. The HMIP Plan recommended that a professional pharmacist should be present on site to audit and quality assure services, to provide advice to detainees and to advise the medicines therapeutics committee. Pharmacy services were therefore reviewed by a pharmacist on site weekly. This was in addition to the full-time on-site pharmacy technician. The Company understands that there would have been different audits done, but due to knowledge loss, it is not in a position to detail them all. It does however understand that one such audit was in respect of in-possession medication. This was conducted monthly in order to ensure that the detainees concerned were still fit to remain in possession of their medication (rather than having to call into healthcare to receive it when due).

113. For audit and quality control purposes, all pharmacy orders were collated by Pharmacy. The Pharmacy Technician controlled stock and checked medication dates. They would also undertake in possession spot checks for detainees. All site medication policies and procedures would also have been reviewed and signed-off by the Company's Chief Pharmacist.

114. The Pharmacist would routinely discuss medication being taken by detainees, any interactions with other medications etc. They would also discuss, where appropriate, alternative medications or dosage.

115. The Pharmacist sat on the site Quality meetings and would give any required feedback and knowledge, any medication trends etc. The Chief Pharmacist led the Company's Medicines and Therapeutic Meetings. Any site relevant information or issues would be fed through to the site via the Pharmacy Technician.

116. The Quality Committee meetings, as above, took place quarterly. The trends of medication were discussed. Matters for discussion would be trends of dispensing medication or if there were any alerts from certain medications that needed to be discussed. Updates from Company's Medicines and Therapeutic Meetings would be fed through as e-mails and healthcare would work on any actions from there. Pharmacy action plans were usually actioned by the Pharmacy Technician and/or the Head of Healthcare.

117. The Company has been reminded that the IMB Inspection report of 2016 ('2016 IMB Report') [ref: IMB000121] concluded that healthcare provision at Brook House was "*adequate*". The report stated that only 29% of individuals felt that healthcare was good. The report added that "*Many detainees we spoke to were negative about their experiences of health care, but we could find no evidence to support these perceptions apart from health notices displayed in English. The health interactions that we observed were polite and professional.*"

118. The 2016 IMB Report also concluded: "... *Of greater concern to the Board is a fairly constant refrain from detainees about the attitudes of some nurses towards them*

– allegations that they can be dismissive, brusque and even rude. We see this in formal complaints and more frequently hear it directly from detainees. This will not apply to the majority of nurses who are doing an excellent job. The Board acknowledges the pressure nurses can be under as the front line for detainees' medical demands. Nevertheless, it is a concern which should be addressed."

119. The Lampard report [ref: CJS0073709] at 11.31 stated: "*Detainees expressed strong views about healthcare at our two meetings. Concerns ranged from access to services to the relationship between healthcare professionals and the Home Office immigration staff. Summary points from our discussions include*:

"You cannot make an appointment to see healthcare. Every morning there is a first come first serve queue. There are long lines of people waiting to be seen."

"There is no such thing as mental healthcare in Brook House"

"Healthcare give paracetamol for mental health issues."

"Doctors play the part of the Home Office. They seem to ask questions on behalf of the Home Office and talk to detainees about their immigration cases inappropriately. Doctors minimise medical issues to enable the Home Office/push Home Office agenda. Detainees feel like doctors are trying to please Home Office re rule 35 assessments."

"Detainees feel that the attitude of healthcare staff is not kind."

120. It is not possible for the Company to respond to the specific comments attributed to it when it has no underlying knowledge as to any of the detainees, their medical history, medical needs nor any context as to the discussions that took place between the detainees and relevant interviewers/inspectors.

121. That said, the Company does consider that a number of factors may have contributed to detainees' negative views and/or perceptions of healthcare. For example,

healthcare staff were often the first to make assessments on whether detainees were fit to fly or be detained; the answers and responses given were not always what they wanted to hear.

122. Some detainees would seek to get fast-tracked through the NHS to get onto a hospital waiting list for treatment on the assumption that being on such a waiting list would prevent deportation until the treatment had been provided and/or seek to stay in the UK until the treatment had been provided.

123. Additionally, some detainees were used to a different healthcare regime entirely: some countries offer stronger medication immediately, whereas the Company, like the NHS, followed NICE guidance, which was often to start with lower dosage of medication, only then increasing if/when necessary.

124. All complaints made against healthcare were fully and properly investigated with any necessary actions taken. Staff would also be reminded regularly that detainees had to be treated with dignity and respect, and as addressed earlier in this statement, Equality and Diversity training was increased from every 3 years to every 1 year.

125. The CQC was responsible for regulatory oversight of healthcare at Brook House. The CQC, in conjunction with HMIP undertook inspections in 2016 and again in 2019. No requirement notices were issued and there had generally been good feedback from the CQC when they conducted their visits.

126. All Healthcare actions from the HMIP inspections of 2016 and 2019 were completed.

DISCIPLINARY ACTION NOT RELATED TO PANORAMA

127. No Healthcare staff were disciplined for matters related to the mistreatment of detainees, but unrelated to Panorama.

COMPLAINTS

128. There were a number of available means by which detainees (and others) could have raised complaints concerning the provision or lack of healthcare services at Brook House.

129. Detainees were able to raise matters informally by speaking directly to healthcare staff.

130. Detainees were however able to make written complaints by completing a complaints form. These were located on each residential wing and in healthcare, and were in a number of languages. These would then be dropped into a designated post-box (located on the wings and in healthcare). These would then be collected by healthcare, who would follow-up and respond to each complaint.

131. There was a separate HO post-box for detainees unable to write in English. This post would be collected by the HO, translated and then sent to Healthcare to investigate and respond in the normal way.

132. As with any NHS patient, detainees were also able to raise complaints directly with NHSE.

133. There was a generic e-mail account which was open to any person i.e., detainee friend, family member, NGO (Non-Government Organisation) or member of the public, to bring any matters to healthcare's attention. However, it was not always possible to give a detailed individual response to all complaints, particularly where they concerned healthcare provision, as for data protection reasons detainee consent would have been required. However, follow-up actions would, in such a situation, have been taken up directly with the detainee concerned.

134. With regards to complaints, where investigations were required, this would involve speaking to the detainee where necessary in order to get a better understanding of the issue(s), talking to other relevant persons of interest, reviewing the medical records and notes etc.

135. Most complaints were dealt with internally. However, serious matters of concern were referred to NHSE. The Head of Healthcare would use her discretion in relation to serious complaints. This would for example be complaints concerning senior management within healthcare or in other such cases where she felt it would not be appropriate for the investigation to be conducted locally. Detainees however always had the right to take any complaint up directly with NHSE, which was advertised locally. Any complaints about external services, such as hospital visits or treatment could also have been raised directly with NHSE.

136. The Company's involvement with any subsequent complaint investigation carried out by NHSE was normally limited to the sharing of relevant data, documents, policies, procedures etc. and to provide such assistance as was requested.

137. Any follow-up actions required through complaints, either internal or through NHSE were captured on the Action Plans. The exact steps would depend on the nature of the complaint. If for example it related to a policy issue, the requisite policy would be reviewed to determine whether any changes were required. If it related to medication, the circumstances would be reviewed in order to avoid any repetition. Healthcare would also looks at trends in order to identify any issues. The complaint investigations were conducted the clinical leads and signed-off by the Head of Healthcare.

138. All complaints submitted during the Relevant Period have been provided to the Inquiry [ref: CJS0074019 - CJS0074038]. There were no NHSE investigations during this time.

139. The complaints process during the Relevant Period was in line with the NHSE complaints policy and no changes were made as a result of any matters arising from the Panorama programme.

WHISTLEBLOWING

140. There is a Group wide whistleblowing policy in place. This therefore applies to all companies within the G4S Group, including G4S Health. A copy of the policy has been disclosed to the Inquiry [ref: CJS000707].

141. In summary, the service is openly available to all members of staff and is heavily promoted through internal notices, posters put up around Brook House etc., and through the Group Intranet. There is also a dedicated Speak-Out website.

142. The service can be contacted directly by telephone or through the website. All enquiries are dealt with by an independent organisation who will take all relevant details of the complaint. If the complaint is such that an investigation is required, a dedicated investigator will be appointed. The investigator will be a senior G4S UK&I Region manager/employee.

143. The investigator will investigate the complaint, acting with the full authority of the Company to access all relevant company premises, equipment, documents and materials. They are also authorised to interview any person of interest, if necessary.

144. On completion of the investigation, a factual report will be submitted setting out whether the complaint is proved. If so, the report will detail what went wrong and why. It will also set out recommendations as to how such matters may be prevented in future.

145. It is not for the Company to comment on employees other than its own; as above, no mistreatment concerns were ever raised through Speak-Out by any of the Company's employees, or as far as I am aware, by anyone else. The matters highlighted in the Panorama programme never therefore reached the attention of senior management.

146. Speak-Out is a platform to allow employees to reach out to report serious wrongdoing and is designed around investigating and responding to such reports. As far as I am aware, only one Company employee was observed to act in an unacceptable manner, which was not observed by any other Company employee. The Company does not therefore accept that the absence of any Speak-Out report in this regard constitutes

a failure of the Speak-Out policy and the Company is confident that had any such complaint been received, it would have been dealt with.

147. It is not for the Company to comment or speculate on other organisations or agencies, such as the HO, IMB, HMIP, Gatwick Detainees Welfare Group, Medical Justice or any other visiting organisation as to whether they did, could or should have spotted the mistreatment of any detained person. The Company is however confident that had any such organisation raised any such issue with it, it would have been treated very seriously. The Company would have welcomed such input from external bodies, which would have improved effective oversight and governance. It is disappointing that such bodies did not provide any such meaningful input.

GATWICK DETAINEES' WELFARE GROUP ('GDWG')

148. GDWG attended Brook House as visitors and therefore would not have been visible to healthcare staff to see who or how often they attended. It would also not therefore be possible for the Company to comment on whether they had all the access to detainees that they required.

149. GDWG does not have an official role. It is a charity that provides support to detainees in the form of advice, befriending, advocacy and practical support i.e., help with clothing etc.

150. Healthcare staff had little substantive interaction with GDWG. It is not in any event for the Company to comment on whether they fulfilled their role appropriately, which largely related to wider custodial and not healthcare matters.

151. Issues would sometimes arise between healthcare and GDWG when they would ask for or seek to discuss medical issues relating to detainees without first obtaining the requisite detainee consent. Where consent had been granted, they would sometimes press for mental health referrals when not qualified to do so although my understanding is that medical staff would carefully consider their views before deciding whether such a referral was appropriate.

MEDICAL JUSTICE ('MJ')

152. MJ would on occasion represent detainees. They would sometimes request copies of detainee medical records and arrange for external practitioners to examine detainees (an option available to all detainees). They would also sometimes submit medical reports for healthcare to review.

153. MJ does not have an official function. It is a charity that provides medical advice and medico-legal reports in support of immigration claims.

154. Given its lack of official function, it is not for the Company to comment on whether it adequately fulfilled its objectives.

155. Based on the information provided to the Company by its former Head of Healthcare, it is my understanding that healthcare did not have any significant difficulties in dealing with MJ. It would often however request copy medical records at short notice, which created challenges although such reports were provided as quickly as possible. There would also sometimes be a disconnect between asserted claims of fitness to detain and observed behaviours of detainees. MJ were nevertheless afforded all reasonable assistance by the complying of access requests for records and providing examination rooms for medical/medical-legal appointments/assessments.

156. The Company is not aware of any complaints from MJ about them not having access to detainees and/or of not receiving adequate assistance in carrying out its work.

ILLICIT DRUGS

157. It is not for the Company to comment on operational issues as HMIP reports and/or recommendations with regards to strategic drug and alcohol policy are custodial operational matters for CJS.

158. However, in April 2016, healthcare undertook a seminar on new psychoactive substances ('NPS') which provided training to staff in this area. A copy of the Briefing has been disclosed to the Inquiry [ref: CJS0073829]. There was also additional further

training provided by NHSE on 25 May 2017. The Company does not however have any documents in relation to this training given that it was provided by NHSE.

159. Forward Trust (known at the time as RAPt) was commissioned by NHSE to provide psychological care to detainees with drug and alcohol issues and prepared in-cell NPS packs for detainees. In respect of those detainees on any substance misuse programme, they would be reviewed by the GPs. Multi-disciplinary team meetings would also be held as appropriate for case discussion/planning.

OCCUPATION OF BROOK HOUSE

160. It is not for the Company to comment or speculate on operational matters concerning the custodial operating environment, particularly in terms of structure and as to whether new arrivals should have had a dedicated induction wing as opposed to being mixed with already established residents. Nor is it for the Company to comment or speculate as to whether those structures were a factor in the mistreatment of any detained person.

161. E-wing and CSU were generally quieter due to having less people. They were therefore better suited for those requiring constant watch due to suicide or self-harm risk. Whilst CSU did take refractory detainees who could be noisy, there was a high staff ratio in the wing, which was again helpful for managing those at risk of suicide or self-harm.

USE OF FORCE

162. In the case of planned use of force, healthcare staff would have attended the incident briefing in advance of the planned use of force. They would therefore have contributed accordingly as to any particular health issues or disabilities which needed to be taken into account in the event planning. Healthcare staff would also have been present, with emergency medical bags, throughout the use of force event to act if required.

163. In the case of unplanned use of force, healthcare would have been notified by CJS staff by telephone where they would then attend the scene with emergency medical bags as soon as possible. Upon arrival, they would have relayed any relevant medical information and as with a planned event, would have remained present throughout.

164. Healthcare staff had no role to play in de-escalation of events which may have led to use of force being deployed and all decisions taken as to the deployment of the use of force were taken by the CJS staff.

165. Healthcare staff had no other role to play in use of force incidents unless they were required to step-in to halt the event should the detainee concerned appear in a state of collapse or experience breathing difficulties. The Company's former Head of Healthcare has confirmed that this would have been done by the nurse issuing an instruction 'Medical Emergency – Hands Off'. The officers concerned would then have stopped the event to allow healthcare staff to attend to the detainee. The incident then moved from a Use of Force incident to a medical one, in line with MoJ guidance on Use of Force [ref: CJS0000063].

166. On occasions following use of force, detainees were moved to CSU. This formed part of the event, and therefore, healthcare staff would have remained present during the move. However, all decisions taken as to the use of CSU were taken by CJS and healthcare played no part in the decision making process.

167. In relation to the use of force in circumstances involving self-harm. This would only have been used to prevent further injury. However, as already explained, use of force, in any circumstances, was only used by custody staff and healthcare staff would attend to such incidents in the same way as any other use of force incident as also already explained; there was no specific guidance on the use of force in respect of use of force in this type of situation as the nurses role was the same.

168. Healthcare were not responsible for arranging debriefs following the use of force, as these were operational matters for CJS, who were responsible for deploying

and planning such events in accordance with the requisite rules, regulations and policies. Healthcare would be invited to all serious incident debriefs, and some other debriefs but not all.

169. It is not for the Company to comment or speculate on why, if applicable, CJS did not subsequently arrange a use of force debrief.

170. There is no DCR or HO rule or regulation which required healthcare staff to attend every Use of Force debrief. This may therefore explain why it was not always invited to attend every meeting.

171. It was not the role of healthcare to consult or canvass feedback from detainees in relation to the use of force as part of the debrief process. Healthcare would however have duly investigated and responded to any subsequent complaints made to it in relation to any such incidents.

172. An F213 form should have been completed by healthcare staff after every use of force event. On the basis of the documents available, there is a small number of occasions where this form is not included within the use of form packs. Due to loss of knowledge, it is not possible for the Company to state for certainty why this is. Possible explanations for these rare occasions may have been because healthcare were not present during a use of force event (unplanned). Healthcare may also have on occasions been dealing with several incidents at the same time, resulting in some F213s being overlooked. It also cannot be ruled out that the forms were completed but may have been lost It was however the responsibility of the officer in charge of the use of force event to collate all required paperwork and to seek the same from healthcare on those small number of occasions where it may have been initially overlooked.

173. Use of force review meetings were arranged and carried out by CJS. Healthcare staff were invited to attend, but these were CJS meetings and healthcare staff's involvement was limited. Any staff actions (in respect of healthcare) required to be

taken following any incident would have been taken forward through an investigation and any lessons learned would have been fed back to staff via staff meetings.

174. Examples of follow up actions would be of perhaps the nurse being observed to be not standing in the appropriate place, so recommendations would be made to healthcare staff to remind them to be more visible to detainees and to ensure they had a clear view of the use of force in order to provide appropriate assistance if needed.

175. As far as the Company is aware, there were no investigations specifically concerning any member of healthcare staff as a result of any use of force review.

VULNERABILITY OF DETAINED INDIVIDUALS

176. The HMIP Report in March 2017 recommended that all staff should have effective training in adults at risk guidance and that there should be effective multidisciplinary oversight of detainees in this group.

177. Adults at risk training was the responsibility of the HO, who provided the training to healthcare in 2018.

178. With regards to oversight, this was multidisciplinary, it was led by CJS not healthcare. CJS held weekly meetings. These were initially known as DOI ('Detainees of Interest') meetings but are now known as the Adults at Risk ('AAR') meetings, which better reflects their nature. The meetings were attended by the Head of Custody (CJS), Head of Safeguarding (CJS), with representatives from healthcare, HO, the IMB and any relevant caseworkers in specific areas. The meetings were minuted by CJS.

179. Healthcare staff collated a log every Monday of any new detainees fitting the AAR criteria. This would then have been updated by CJS Safer Custody and HO as required and discussed at the next AAR meeting.

180. The Company has been asked to comment on the following: *The IMB 2016 Inspection report recorded at 5.4.10: "It is surprising that there are so few [rule 35]*

reports by GPs about detainees whose health is likely to be affected by continuing detention or suspecting that a detainee has suicidal intentions – given that reporting from G4S showed an average of 11 incidents of self-harm attempts per month in 2016."

181. This issue has already been touched upon in this statement: the majority of self-harm incidents did not meet the criteria of real suicide intent.

182. All detainees on an ACDT for one week or more would have been reviewed by a GP.

183. All requisite changes to Detention Centre Rules were the subject of ongoing review and would be discussed at meetings where appropriate, such as the quarterly meetings with the HO and NHSE.

184. The Company has been asked to summarise a number of policies. It therefore does so in the paragraphs below. The Company's policies were in place as a matter of good governance and in compliance with its obligations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

185. Compliance monitoring was the responsibility of the Head of Healthcare (also the CQC Registered Manager), and issues as to compliance (or not) would have been picked up through audits and reviews, as well as through investigation and analysis of complaint trends etc.

186. All staff were required to be familiar with, and to keep abreast of, all Company policies and procedures. All policies and procedures were posted on the Company's intranet site, which was readily available and accessed by all staff.

187. The Company operated many other policies and procedures, but it does not consider that any others are relevant.

MEDICINES MANAGEMENT [REF: CJS000728]

188. This policy was issued in March 2017 and reviewed in February 2019.

189. Purpose:

- To promote the safe and effective use of medicines used by the range of healthcare professionals employed by G4S Health Services Limited.
- Sets out safe systems for supplying, prescribing and administering all medicines used by G4S Health Services whilst still ensuring appropriate and convenient access for patients.

190. What the policy sets out:

The policy identifies who within G4S Health Services is responsible in relation to different areas of medicine management e.g. controlled drugs. It identifies who oversees risk assessments and explains the process for purchasing medicines from an external supplier.

- Medical Director of G4S Health Services has overall responsibility for the safe and secure handling of medicines and is the Controlled Drugs Lead.
- Day to day management of medicines is devolved to the Chief Pharmacist, and delivered via Director of Nursing and Regional Clinical Managers.
- G4S Health Services Health Excom is responsible for monitoring the effectiveness of the policy and ensuring sufficient resources are available to implement the policy.
- The Chief Operating Officer is responsible for safe procurement of approved and appropriate quality medicinal products and ensuring that staff are appropriately trained.
- Head of Quality, Audit and Compliance assists the COO in monitoring the implementation of the policy, ensuring systems are followed and overseeing formal risk assessments.
- All Health Care Practitioners (HCP) must be fully trained in accordance with their profession.

191. Storage and access to medication:

- Different categories of medication must be stored in a locked cupboard or approved drugs bags or pouches.
- Controlled drugs must be managed in accordance with NICE guidance (April 2016).
- Records must be kept.
- Verbal orders for administration or supply of medicines should be infrequent and must follow the system put in place.

192. In possession medication process:

- Is not applicable to any drugs that are liable to misuse in a prison setting.
- Patients must be risk assessed and deemed fit to keep their medication in-possession. This must be reviewed periodically.
- The policy also outlines what must be done in the event of an error in administration or an adverse drug reaction is suffered by a patient.

MENTAL CAPACITY POLICY [REF:CJS000730]

193. This policy was issued in April 2017 and reviewed in April 2019.

194. Purpose:

- Sets out the main features of the Mental Capacity Act 2005 ("the Act") and identifies the duties placed on health and social care staff.
- It provides a procedure to determine the circumstances in which the various processes described within the Act are initiated.

The policy is to be considered when staff carry out any act in relation to care that requires a patient over the age of 16, their carers or relatives to make a decision or choice. All acts related to a patient's care require their informed consent, except in the particular circumstances detailed within the policy

195. What the policy sets out:

- The policy refers to specific sections of the Act throughout in relation to assessing whether a patient lacks capacity, how to decide what is in a patient's best interests and when it is appropriate to restrain a patient.
- The policy lists other legislation that applies in conjunction with the Act, under which health and social care staff have obligations and outlines when health professionals may need to refer to the Mental Health Act as opposed to the Act.
- The policy confirms there is a criminal offence of ill treatment or neglect of a person who lacks capacity.
- All health and social care staff must adhere to the principles of the Act and follow the Code of Practice to assess capacity and act in the person's best interests.
- Roles and responsibilities are outlined within the policy and the types of decision-makers referred to within the Act, namely Lasting Powers of Attorney and Court of Protection appointed deputies.
- Contains a template for assessing and recording a person's capacity and a best interest checklist.

SAFEGUARDING ADULTS [REF: CJS007079]

196. This policy was issued in April 2016 and reviewed in May 2018.

197. Purpose:

- To ensure all staff understand and act in accordance with their roles and responsibilities in relation to safeguarding and promoting the welfare of Adults at Risk and have the knowledge and understanding to be able to recognise and respond to adults at risk of harm and abuse.
- To ensure the relevant procedures are in place to support staff and to clarify the line of responsibility within G4S in relation to safeguarding.

198. What the policy sets out:

- Applies to all colleagues whether employed directly or indirectly by G4S.

- What safeguarding is.
- When and how to make a referral to a Local Authority.
- Mental capacity and consent.
- Outlines the importance of striking a balance between confidentiality and sharing information in relation to adults at risk.
- The importance of accurate record keeping and the deadlines for reporting any concerns.
- Appendix listing staff roles and their specific responsibilities in relation to safeguarding adults.
- How to report members of staff who are suspected of abusing or mistreating an adult.
- How staff can seek support following challenging or distressing safeguarding occurrences.
- Audit and monitoring of the policy and a references section providing links to statutory guidance and legislation referred to within the policy.

DETENTION SERVICES ORDER 09/2016 – DETENTION CENTRE RULE 35 V4.0 [REF: HOM002591]

199. This is not a Company document or policy, but guidance issued by the Home Office in December 2016. The Company understands that the current version is v7, which was published in March 2019. The response below is in respect of v4.

200. Purpose:

- To guide and inform Home Office staff, immigration removal staff and healthcare staff working in immigration removal centres ("IRC") as to the preparation and consideration of reports submitted in accordance with rule 35 of the Detention Centre Rules 2001. rule 35

201. What the policy sets out:

- The responsibilities of medical practitioners and healthcare staff working in an IRC in relation to Rule 35 reports.

- The process for healthcare staff to screen new detainees on arrival, asking the appropriate questions regarding whether they have been victims of torture and making appointments with IRC medical practitioners, if necessary.
- How a medical practitioner should prepare and submit a Rule 35 report, explains the three different reporting categories and provides a template report for each one.
- Lists the actions that are required to be taken by Home Office staff once they have received a Rule 35 report and the deadlines for responding.

HOME OFFICE DETENTIONS SERVICES ORDER, THE PROTECTION, USE OF SHARING OF MEDICAL INFORMATION [REF: CJS007077]

202. Purpose:

- To provide information to staff and suppliers on the protection, use and sharing of confidential clinical information.

What the policy sets out

- The importance of "medical in confidence" information and knowing when to share it i.e. when it is relevant to the identification of a risk of self-harm/suicide or to an individual's healthcare needs.
- The risks of not sharing information and how the Data Protection Act does not completely prohibit the sharing of information.
- Advice to medical practitioners from the General Medical Council on disclosing information for administrative purposes.
- How and when sharing information without an individual's consent may be necessary.
- The process for deciding when to detain or release an individual from detention.
- The process for sharing information about medication and handling medicines during escort.

- Template Forms of Authority for the release of healthcare and medical information and template Discharge Advice Notices when individuals are transferred from healthcare to escorting officers.

STATEMENT OF TRUTH

I believe that the facts stated herein are true.

I am duly authorised to make this statement.

I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: Signature

Dated: 2/2/22