BROOK HOUSE INQUIRY

FIRST WITNESS OF HAVVA DAINES

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 1 October 2021.

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

I, Havva Daines, of DPA will say as follows:

Background

1. My full name is Havva Daines and my date of birth is DPA

2. I first qualified in 1988 in Turkey and I have worked as a registered general nurse ("RGN") for 25 years. I have been working at Brook House for 11 years since April 2010. I worked in a hospital in Turkey previously in the A&E department. I moved to England in 2001 and worked in a nursing home for 10 years before starting work at Brook House.

3. I started work at Brook House as a RGN and became a senior nurse in 2014. I worked as a senior nurse until 2020 a Sensitive/Irrelevant

Sensitive/Irrelevant

4. Sensitive/Irrelevant

Application Process

5. Before I began working at Brook House, I had worked in a nursing home for 10 years and I wanted a change. My job was becoming a mundane routine and I felt I needed a new challenge. I had never worked in a secure setting before and was looking forward to a new experience.

6. I felt prepared for the role at Brook House due to my previous training and qualifications. Nurses know what they are doing. I was given further relevant training by G4S and my initial interview took place in Brook House, so I was able to familiarise myself with the setting I was going to be working in. I was shown around the centre as part of the interview process. I thought this was very helpful in terms of preparation.

Culture

7. When I started in Brook House, it was a nice place to work. Since the Panorama programme aired, it is a lot stricter and staff members are a lot more wary of each other. We had more staff members when I first started working in Brook House.

8. Staff morale was very low after the Panorama documentary, prior to that it had been ok. Everyone was so shocked and saddened at what they had seen on the footage. Brook House was not a nice place to work during that time. During the Relevant Period there was also lots of Spice being taken by detainees. This was a new drug that had made its way into the centre. This was a very difficult time for healthcare staff, as there were so many emergency first responses as a result of Spice. This was very difficult to manage on top of our already substantial workload.

9. All staff members were always willing to assist the detainees. Everyone was there to help them. I never witnessed any behaviour from any member of staff that caused me concern. All officers and healthcare staff were very polite to detainees.

10. I did not have any concerns about the general treatment of detainees at Brook House.

11. I think the management of individuals with physical health conditions suffered during the Relevant Period. Healthcare staff were very overworked and the spice outbreak meant that it was hard to provide the adequate level of care to detainees with physical health conditions at times.

12. Admission lists were sometimes very long. If new detainees were suffering from medical issues, they would not be seen by the GP until the next day due to the large numbers. This was sometimes difficult to manage.

13. I did not have any concerns about the protection of detainees who were considered vulnerable.

14. During the Spice outbreak around the Relevant Period, we had to respond to a lot of emergency calls. This would create a lot of extra work for healthcare staff. I think staff members should be randomly spot checked to ensure they were not bringing drugs into the centre. This would help put a stop to the substance misuse issues.

15. I did not have any concerns about the protection of specific individuals from the type of abuse seen on the Panorama programme.

16. I am not aware of any occasions where a member of healthcare staff raised concerns about the treatment of individuals.

Oversight

17. ***The Independent Monitoring Board (IMB)*** Healthcare staff have contact with the IMB on a daily basis. If the IMB have concerns about the detainees, they come to healthcare and ask us about them. The IMB were there to ensure that the detainees were well looked after. They monitored their wellbeing.

18. ***The Gatwick Detainees Welfare Group (GDWG);*** If detainees cannot afford lawyers, GDWG help them. GDWG are there to assist with detainees' personal issues for example, arranging contact with their families. We had daily contact with GDWG, as they would also come to healthcare to request further information about detainees.

19. ***Medical Justice;*** Medical Justice ensure that the detainees are looked after. If detainees have any complaints, Medical Justice deal with those. They instruct their own medical practitioners to come in and examine detainees or look at the detainees' medical papers. We have regular contact with Medical Justice, as they would request healthcare records from us.

20. ***Bail for Immigration Detainees (BID).*** I did not have much involvement with BID at all. I think they were there to help detainees apply for bail and fill in the relevant paperwork.

21. ***And other external organisations;*** We had external psychiatrists, dentists and opticians that used to come into Brook House. Opticians used to come in every month and dentists every 2 weeks. The psychiatrist would come every week or if a detainee needed urgent psychiatric help, they would come in when called.

General Training

22. Before starting work at Brook House, we had a variety of training. We had immediate life support training, key security training, safeguarding training, ACDT training and personal protection training. They were all done face to face. All other training was done online such as chronic disease management, hygiene training, and fire safety training. Some training sessions were provided by external companies whereas G4S conducted other sessions.

23. I think the training prepared me well for my role in Brook House. I felt well equipped to carry out the role however I do think that the training should have included suicide prevention sessions. I think they would have been beneficial.

24. I think ACDT, immediate life support training and chronic disease management were necessary in order to fulfil my role.

25. I think suicide prevention should have been included along with secure setting training. This would have been helpful to people like me, who had not worked in such environments before.

26. Immediate life support training is done every year. Personal protection training and ACDT training are done only once. I think it would have been helpful to have refreshers every year for those. All mandatory nursing training must be done yearly.

27. As previously stated, the training was provided by a mixture of companies, some of it was provided by G4S however I do not have a list of the different providers for each course.

28. I didn't have much C&R training at all. I was given a leaflet explaining what to do in relation to use of force but I did not have formal training sessions at any point.

29. I did not receive any Rule 35 training. I had ACDT training during the induction, which was helpful as it familiarised me with the documentation and how to fill it out. There were no refresher training courses. I did not receive any training regarding suicide or self-harm.

Staff Induction

30. I had a very good staff induction. Brook House was not understaffed when I first started, so there were plenty of nurses to provide help and training. John Holgate was my manager at the time and Gwyn Williams was my deputy manager. They both carried out my induction. I shadowed them along with other healthcare staff and was taken out on to the wings and familiarised myself with the procedures. My induction lasted for around one month.

31. I felt very prepared for my role following the induction process. It was very thorough and I was supported by many members of staff throughout.

32. I did not experience any problems with the staff induction process.

33. I cannot think of anything that could have been improved in relation to my induction.

Management of healthcare staff

34. In healthcare, we had a Head of Healthcare, two practice managers, a clinical lead, a number of senior nurses, staff nurses – RGNs and registered mental health nurses, healthcare assistants and admin staff.

35. No members of staff reported to me as line manager.

36. All managers were easy to find if they were on site. They would always be in their office. If they were not in Brook House, I could always call their work phone and get in touch with them. Sandra was very approachable and I felt comfortable going to her with any issues or queries.

37. Sandra Calver, who was Head of Healthcare, was my line manager. I was supervised regularly by Chrissie Williams, who was clinical lead or Jo Buss, a senior nurse. Jo was often based in Tinsley House. We had sit down meetings monthly or sometimes every 2 months. If I required an earlier meeting, I would let Jo know and this would always be arranged.

38. Prior to the Relevant Period, we had begun using agency staff. I found that some of them were difficult to work with as I didn't feel that they worked as hard as the permanent staff. All of the permanent staff members worked well together. I always felt able to rely on them, as we had a very good working relationship.

39. Clinical supervision usually took place out on the floor. Whoever was carrying out the clinical supervision would observe the staff as they worked.

40. Most of the time it was Sandra or Chrissie who carried out my clinical supervision. They were both in the building 5 days a week. My clinical supervision took place via a one to one meeting.

41. I did not experience any problems with my line management or clinical supervision.

42. It would have been more helpful if Sandra and Chrissy were on the floor when carrying out their supervision.

Disciplinary and grievance processes

43. I was never involved in any complaints.

44. I was never involved in any disciplinary or grievance procedures.

Staffing

45. Staffing levels were low in Brook House during the Relevant Period. We began using agency staff in around 2015, as G4S were struggling to recruit permanent staff. The staff levels in the permanent staff are still very low now.

46. I don't think there were sufficient staffing levels to provide adequate healthcare to the detainees. We did our best but some days, I don't think it was enough. We were still understaffed even with agency staff. There were too many detainees and not enough healthcare staff to meet their needs. Sandra and Chrissie were aware of the staff shortages, so I did not ever raise it formally. They could see that we were understaffed but they were advertising and could not recruit.

47. I think the proportion of permanent healthcare staff to agency staff was around 50:50.

48. Most of the agency staff had experience of working in prisons. They were very good at working with the detainees.

49. G4S tried to book regular agency staff, so that they were more familiar with the systems and procedures in Brook House. I am not sure what training they had. I don't think they received personal protection training or ACDT training.

50. Some of the agency staff came to work in Brook House and left after a short period. They said they could not work in this kind of environment. Some said that Brook House was not a safe setting, they would claim it was not as safe as the prisons they had worked in previously. This had a detrimental effect. Permanent staff would see the detainees on a daily basis and know their conditions very well. Agency staff would see them and then not come back for a month. Permanent staff were able to build better relationships with the residents and gain their trust more.

51. Sometimes there was so much Spice going around Brook House and so many first responses to attend, we would have to close the triage clinic. We wouldn't be able to see the detainees and manage all of these emergency call outs. There were only 2 nurses on a shift sometimes and it just was not possible. We only had one healthcare assistant during the Relevant Period. An appointment system would have been more beneficial, similar to what the GP has. This would mean healthcare staff could be more organised and plan their days better.

52. Staff shortages caused staff morale to very low. There was so much work to be done and there was not enough healthcare staff to manage it all. I did feel it was unsafe at times, as we were so outnumbered by detainees.

53. I think we had a lot of officers during the Relevant Period. The staff levels seemed ok on the wing. Officers used to complain that they were understaffed during the night shifts but I only worked nights on a rare occasion, so I cannot comment.

54. I cannot comment on the staffing levels of the activities team.

Relationship between Healthcare and Detention Staff

55. Healthcare used to call the Oscar managers if we required their assistance with a detainee and they would perform a control and restraint procedure. They were always very efficient and professional. We would have daily contact with the officers. If they had any concerns about a detainee, they would refer them to us for assessment. They looked after detainees well. I never saw any unprofessional behaviour. We had a good working relationship with the officers.

56. I never experienced any problems with the relationship between healthcare and detention staff.

57. I did not raise any concerns, as I did not experience any problems.

58. I think healthcare could have had more staff. It would have been helpful if there were regular officers to assist with healthcare to ensure that we always had the support we needed.

Relationship with Home Office

59. Sometimes healthcare would have daily contact with the Home Office. If they had any medical concerns or any queries about a detainee, they would email us. If we could not assist with their requests, the e-mails would be answered by Sandra or Chrissie. Home Office staff were situated on another floor within our building, so we had some face to face contact with them. If a detainee was being reviewed, they would often attend.

60. Sometimes healthcare would clash with the Home Office regarding detainees and their suitability for detention. Healthcare would make a decision that a detainee was not fit for ongoing detention and Home Office would sometimes challenge and overrule it. For example, if a detainee was suffering with very high blood pressure and was at risk of a heart attack, we would argue that they should not remain at Brook House. The Home Office did not seem to understand the severity of certain health conditions and believed the detainees could still receive adequate care in Brook House. This was frustrating for us.

61. This would definitely cause morale levels to drop. We wanted the detainee to be released, as we knew that being in Brook House was detrimental to their wellbeing. We wanted to prevent any further harm coming to the detainee.

62. It occasionally had an impact on the ability of healthcare to fulfil our roles and provide adequate care, as we thought the best thing for them was to be removed from the centre. We could not continue to provide the care these detainees needed, which is why we deemed them unfit for detention.

63. I think Home Office should trust healthcare staff's judgement. We are trained in these areas, we know when a detainee is too ill to be in in Brook House. Our opinions should be respected.

Reception / Healthcare Screening / Induction

64. Detainees were to be health screened within two hours of arriving at Brook House.

65. Health screening could take place at any time. It was a 24-hour service.

66. Healthcare screening took place in the two admissions rooms on the ground floor of Brook House.

67. At first it was only RGNs or RMNs who could carry out healthcare screening but after a while, healthcare assistants were also trained up.

68. Detainees could always have access to an interpreter if required during admissions screening. We used BigWord at the time.

69. Detainees would be given a leaflet containing information about healthcare upon arrival. The leaflet contained information about accessing healthcare, triage times and medication administration.

70. If a detainee was arriving at Brook House from prison or another detention centre, we would have access to their medical records as we all used the same system. If they were arriving from elsewhere, we would often have to request their medical records. The detainees would have to sign a form of authority to confirm that they consented to us having access.

71. If an individual arrived at Brook House with medication in their possession, the GP would have to assess the detainee to confirm that he was happy for them to keep the medication in their possession. The detainee's medical records would also be reviewed to confirm that the medication had been prescribed.

72. If an individual arrived on medication but without it in their possession, we had emergency medication in Brook House that the GP could prescribe to the detainee if they needed it urgently. The GP would always assess the detainee before prescribing any medication. It would then be arranged for the detainee to receive that medication however many times a day they required it.

73. If an individual arrived at Brook House and was suffering from a diagnosed physical health condition that was so severe that we could not manage it around the centre, we would refuse admission. This would only be in extreme cases for example, if the detainee was in a wheelchair. In other cases, a Supported Living Plan would be opened to notify everyone in the centre of the detainee's specific needs.

74. If an individual was suffering from a diagnosed mental health condition, we would refer the detainee to the mental health team and ask for an assessment to be carried out. In some cases a SLP or ACDT would be opened to provide the detainee with further support and notify officers.

75. If an individual arrived at Brook House and was deemed to be vulnerable, we have a safeguarding booklet that we would give out to them. We would inform the officers and in more severe cases, the detainee could be moved to E-Wing for constant supervision.

76. We ask all detainees to undertake a urine test upon arrival in Brook House. If a detainee was suffering with substance misuse issues and it was controlled, we could place them on the

normal wing. If the detainee was experiencing severe withdrawal symptoms then they would be placed on E-Wing for higher levels of monitoring.

77. If an individual was assessed as being at risk of self-harm or suicide, we would open an ACDT document and refer the detainee to the RMNs. If the RMNs deemed it necessary, they would arrange an appointment with the psychiatrist for the detainee.

78. All new detainees would go to the induction wing initially for their first night in Brook House. I can't remember when it changed exactly but they now all go to different wings upon arrival. All new detainees are given information about how to access healthcare. Healthcare is a 24 hour service. If a detainee needed to see a nurse, they could tell an officer and we would be alerted immediately.

79. A GP appointment was arranged for all new detainees to attend the following day. If detainees needed healthcare assistance through the night, they could alert an officer or ring their call bell for an officer to come to them.

80. This was the usual process and did not differ in any way.

Healthcare Facilities and Equipment

81. Healthcare was located in the middle of the building, so it was very easy to access. There were no windows as a result of its location. We had an office, the GP's room, the nurses' clinic and a pharmacy. The mental health room was in a different area but not far. We also had two admissions rooms downstairs.

82. Healthcare had all of the physical resources the detainees required to deal with their health conditions. I can't think of anything that we were lacking in terms of physical resources.

83. I think healthcare had all of the equipment to deal with the health conditions presented to us by detainees.

84. I don’t think there were any problems with the physical environment regarding the provision of healthcare to individuals.

85. Sometimes it would take a while for G4S to replace broken equipment. New pieces of equipment could take up to three weeks to come. If we needed something urgently, we could request it from Tinsley House but this was not ideal.

86. Healthcare should never be short of equipment. This is detrimental to the detainees' wellbeing, as it means we cannot provide the care they need.

Access to Healthcare

87. There was a triage clinic every morning from 9:30-11:30 and one in the afternoon from 2:30 until 3:30. They were walk in clinics, detainees did not need an appointment to attend. The pharmacy opened in the morning from 8:30 until 9:15 and in the afternoon from 1:30 until 2:15.

It also opened in the evening from 8pm until 8:45. The GP was appointment based, he was in every day including weekends.

88. RMNs would assess detainees that were suffering with mental health issues. They could also refer them on to see the psychiatrist. Detainees are also offered group therapy sessions.

89. Detainees could attend the triage clinics if they needed to see a nurse. Officers would also sometimes call us from the wing and ask us to come and see a detainee or they would send the detainee to healthcare to be assessed. Healthcare could be contacted 24/7. Anyone could refer a detainee to us or the detainee could self-refer.

90. Detainees would be seen by nurses first and then referred to the GP if necessary. When new arrivals came into the centre, a GP appointment was automatically scheduled for them to attend.

91. Sometimes detainees would come to us and we would refer them to a RMN. A detainee would always have to be seen by a RGN before they could see a RMN.

92. Psychiatrists come in to Brook House once a week. Detainees must first be assessed by a RMN and they will then refer them on to the psychiatrist. Psychiatrists can also be called into the centre at any time to see a detainee if it is urgent.

93. I don't think there were any problems in accessing healthcare. Healthcare was always available to detainees.

94. If there was an emergency first response then occasionally healthcare would be closed. This could cause delays in detainees accessing healthcare. This was due to staff shortages.

95. More nurses are needed in healthcare. This would be very helpful. It would mean first responses could be attended and triage etc. could always still go ahead as planned.

Detained Persons

96. A lot of detainees suffered from stress around the time of the Relevant Period. There were a lot of different mental health issues in Brook House. They were all very stressed about their situation and not knowing what was going to happen to them. They did not want to be there.

97. A lot of the time, there would only be one RMN on shift. This was challenging. We had one senior RMN and one general RMN. This was not enough to treat all of the detainees who were suffering from mental health issues. More RMNs were definitely required.

Interpreters

98. We used interpreters a lot at Brook House. We mostly used BigWord. We would telephone them to request an interpreter. We didn't really use interpreters face to face.

99. I can't remember whether interpreters were always readily available when needed. I think occasionally we would have to wait but they were usually available quite quickly when we needed one.

100. I can't remember if there were any problems with obtaining interpreters for individuals.

101. I don't think the use of interpreters impacted the adequacy of the provision of healthcare to individuals.

Supported Living Plan

102. If a detainee suffered with any medical problems or needed mental support, a SLP would make officers and everyone else in the centre aware of their specific needs.

103. If a detainee was partially blind or had lost any limbs etc. they would have a SLP. SLPs were also set up for individuals who were mentally unwell. SLPs could be set up for short term and long term conditions.

104. Healthcare staff set SLPs up. We would review them weekly or as and when required.

Complaints

105. If a detainee wanted to make a complaint, they would write to us with their complaints and we would inform our managers, either Chrissie Williams or Sandra Calver, and they would deal with it from there. Complaints would have to be put in writing, I don't think complaints could be made verbally.

106. We would get complaints from detainees regarding appointments for Rule 35 reports. The doctors would only schedule one or two Rule 35 appointments per day, so there would sometimes be long waiting times. Occasionally, we would also get complaints regarding medication and detainees being refused medication from doctors. I wasn't involved in any complaints.

E Wing

107. If detainees were dangerous or very violent, or withdrawing from illicit substances or were suffering severely with their mental health then they could be placed on E-Wing.

108. E-Wing was an isolation wing. It was for detainees who required closer monitoring and higher levels of supervision,

109. Healthcare staff would attend E-Wing every day to check in on detainees. If detainees needed to be seen by a doctor then we would arrange it and we would take their medication to them as and when they needed it.

110. If a detainee was violent or was damaging property and becoming a danger to themselves or other detainees, they would be placed in the Care and Separation Unit ("CSU").

111. Healthcare would attend CSU every day to check in on the detainees and provide treatment and support.

Medication

112. If an individual was prescribed medication that could remain in their possession, normally healthcare would assess if the detainee can understand English or not. Some can speak English very well but cannot understand written English. We need to know that they can read the labels on the medication and the instructions for use. There are also some medications under G4S' policy that we cannot allow detainees to have in their possession, even if they were able to have it in prison for example, anti-depressants. This is because these types of drugs are highly tradeable within Brook House.

113. If a detainee was prescribed medication that could not remain in their possession, healthcare administer medication three times a day, in the morning, afternoon and evening. Detainees attend the pharmacy at these times and collect their medication. If a particular detainee required more than 3 doses of medicine in one day, we would arrange a convenient time with them to administer the further dose.

114. Detainees would become annoyed if they could not have medication in their possession that they were used to having in prison. It would also be difficult sometimes to administer diabetes medication, as detainees would need to take it just before lunch. It was difficult to arrange for officers to bring these detainees to healthcare at this time.

115. I think G4S need to review their policy in relation to medication in possession. If prisons deem certain medication safe for detainees to keep then we should implement the same regime.

Drug / alcohol misuse

116. Every detainee would undertake a urine test upon arriving into Brook House. We would review detainees' medical records to see if they had a history of substance misuse and we would discuss the reasoning for their substance misuse with them to find out how we could help.

117. Methadone could be prescribed by the GP if he thought it was necessary following an assessment. There were other medications that could be provided depending on the severity of the detainee's withdrawal symptoms.

118. We had a substance misuse team that came to Brook House daily. The team checked in on the detainees and arranged one to one sessions to monitor the detainees' conditions.

119. I don't think we had enough services in Brook House in relation to substance misuse. For example, we did not have a specific substance misuse nurse, which I think Brook House could really benefit from. We need more training to understand how we can help and treat detainees suffering from substance misuse.

120. More training is definitely needed for staff in relation to substance misuse.

121. During the Relevant Period, there was an outbreak of Spice in the centre. Healthcare staff were attending emergency call outs several times a day. It was a very stressful time.

122. Healthcare staff would give detainees leaflets to explain the consequences of illicit drug use. We would talk to detainees and try to manage their conditions as best we could. We would administer their medication and write notes in their ACDT booklets to monitor their progress and determine what further support they required.

123. The emergency call outs became so frequent that I got used to them. I knew what to expect but it did not make it any less upsetting. As nurses, we felt unsafe. We were so understaffed and the situation seemed to be getting worse.

124. Healthcare staff were always understaffed. Occasionally we could not provide the best care to detainees who were intoxicated, as we were so busy. For example, we were unable to spend as much time assessing or following up with the detainees who were intoxicated, as there was so much other work to be done. We used agency staff but it was still not enough.

125. I did not have any concerns about the appropriateness of detention staff's management of detainees who were intoxicated.

126. I raised concerns with Sandra many times regarding staffing. It was always raised by other members of healthcare staff in meetings but we just could not get the staff.

Mental Health

127. If detainees attended triage complaining of stress or depression, we would refer them to a RMN for a full assessment. An appointment would be made to see a RMN and they would then refer them on to the psychiatrist if they deemed it necessary. Detainees needed to be seen by a RGN before they could be referred to a RMN.

128. I had no concerns about the appropriateness of healthcare staff's management of individuals suffering with mental health conditions. RMNs are very experienced and they managed detainees well.

129. I don't think officers have any mental health training. Sometimes it was hard for them to understand the conditions that the detainees were suffering with. I think mandatory training should be introduced for all officers regarding the management on mental health.

130. I think our managers raised concerns regarding this. I am not sure if anything was changed or if the officers have mental health training now.

Rule 35 reports

131. I was never involved in writing Rule 35 reports. Only the GP can write them.

132. A Rule 35 report is for detainees who have been a victim of some form of torture. It prevents them being sent back to where they were tortured.

133. If a detainee states that they have been tortured then an appointment is made with the GP to conduct a full assessment. If the detainee does not speak English then we will use an interpreter for the assessment. The GP asks the detainee a series of questions and makes a note.

134. I am not sure what criteria is applied to identify suitability for ongoing detention. Sometimes we would advise the Home Office that a certain detainee was not suitable for detention and they would respond and overrule our decision, so I don't know what criteria they use. We usually deemed an individual unfit for detention when they were very mentally ill and their needs could not be met in Brook House.

135. A GP would carry out a face to face assessment with the detainee. The length of appointments would vary but most tended to last about an hour. At the end of the assessment, the detainee will have the chance to read through the report and signs it if they are happy. We then send the report to the Home Office and they would usually come back to us within 7 days with a response.

136. I think Home Office was responsible for ensuring compliance with clinical standards and the effective implementation of the Rules 33-35 of the Detention Centre Rules safeguards.

137. Sometimes it would be difficult to get an interpreter for a Rule 35 assessment. This would slow the process down and increase the wait times for other detainees.

138. I did not have any concerns about the process of assessment and writing of Rule 35 reports.

139. I did not raise any concerns about the process of assessment and writing of Rule 35 reports.

140. More doctors in Brook House would be ideal, as at times a lot of detainees required Rule 35 appointments and wait times could be long.

ACDT and self-harm risk management

141. I would open ACDT documents if I thought a particular detainee required one. I would also attend ACDT meetings on occasion if RMNs were unavailable. This was the extent of my involvement with ACDTs.

142. If officers or friends of detainees recognised that they had been acting differently or appeared to be suffering with depression then they would refer the detainee to healthcare for further assessment. Sometimes detainees would come to us and confess that they had been having thoughts of self-harm or suicide and we would provide support.

143. Healthcare would conduct an initial assessment and talk to the detainee about why they were having thoughts of self-harm or suicide. As we didn't know the detainees as well as the officers, it would often be the officers referring detainees to healthcare who they believed to be at risk.

144. Healthcare staff undertook regular reviews of detainees who were at risk of self-harm or suicide. We would note down any changes in their condition and any medication they were taking within their ACDT booklet.

145. I did not have any concerns about the appropriateness of healthcare staff's management of individuals at risk of self-harm or suicide.

146. I did not have any concerns about the appropriateness of detention staff's management of individuals who were at risk of self-harm or suicide.

147. I did not raise any concerns about the appropriateness of detention staff's management of individuals who were at risk of self-harm or suicide.

ACDT

148. The purpose of an ACDT document was to provide more support to certain detainees who were suffering with their mental health. The ACDT document would contain information from reviews and closely monitor the detainee's condition. Opening an ACDT would make everyone aware that this particular detainee required closer supervision.

149. If a detainee was having thoughts of self-harm or suicide or was generally a risk to themselves, an ACDT document would be opened.

150. There was no threshold for opening an ACDT document. If anyone had concerns about a certain detainee, an ACDT could be opened.

151. Once an ACDT document had been opened, the Oscar managers would need to be informed. The ACDT booklet would need to be filled in by the person who had opened the ACDT, listing the reasons for opening.

152. The detainee would be monitored constantly on an ACDT document and any changes in their mood or behaviour would be noted within their ACDT booklet. Officers would be made aware of the detainee's condition and they would be subject to closer supervision on the wing. Lots of paperwork would be completed in relation to the detainee to ensure that their medication and treatment was recorded.

153. At first there would be daily review meetings for a detainee on an ACDT document. Reviews would be attended by the Home Office, the mental health team, an Oscar manager, the safeguarding team and the detainee. If nobody from the mental health team could attend then a RGN would go in their place. How often the reviews were after the first week would be assessed on a case by case basis.

154. If a detainee no longer required a higher level of support and was no longer having thoughts of self-harm or suicide then the ACDT document would be closed.

155. ACDTs were not really challenged. Sometimes officers would ask for more information about why a certain detainee was on an ACDT but if you were satisfied that the detainee posed a risk to themselves and needed the support of an ACDT, you were never really challenged.

156. Healthcare completed daily check-ins with the detainee. We asked how they were feeling and made notes in their ACDT booklet. Healthcare also attended the review meetings and were involved in discussing next steps for the detainee and their treatment.

157. Occasionally the detainees did not want to attend the review meetings, as they were feeling particularly low on that day. That was challenging, as it made it more difficult to assess them. In these cases we would be forced to postpone the meetings.

158. I don't think there were any improvements to be made in relation to the management of detainees on ACDT documents.

159. I did not attend any Multi-Disciplinary team meetings. They were only attended by deputy managers, Head of Healthcare and the GP. These meetings were to discuss detainees with complex health issues and decide on next steps.

160. Healthcare would normally attend Safer Community Meetings and Adults at Risk Meetings. We discussed any complaints that had been made by detainees and any changes to healthcare and management.

161. Detainees who had witnessed violent or distressing events would be seen by a RMN. There was always someone in healthcare who was willing to talk and offer support.

Food and Fluid Refusal

162. Occasionally officers would come to healthcare and advise that a particular detainee did not appear to be eating. Someone from healthcare would go to the detainee's room and take their weight, blood pressure and blood sugars. The results would tell us if they were eating or not. We would also look inside their mouth and see if it was dry and whether they appeared dehydrated.

163. Healthcare would see the detainee on a daily basis for observation. We would encourage them to eat and remind them of the consequences of refusing food and fluids. In extreme cases, we would transfer the detainees to E-Wing, where they could be placed under constant supervision.

164. Specific food and fluids forms had to be completed and sent to Home Office and the Oscar managers every day.

165. I have had a lot of experience of detainees refusing food or fluids. It is very unpleasant. I would always try to get to the root of the problem and find out why they were not eating. I would offer them support and ensure that they were monitored closely by officers.

166. I think it was difficult to manage the more severe cases where detainees were waiting to be sent to hospital because they were refusing food and fluids. There was not enough space in E-Wing occasionally. I raised concerns with Sandra and I think she escalated it but I am not sure.

Use of Force

167. Normally Oscar managers notify healthcare of any pre-planned uses of force. Healthcare review the detainee's medical records and identify any health issues that need to be reported to the officers beforehand. Healthcare are present at uses of force to ensure that it goes ahead safely.

168. If a detainee is violent or refusing to leave Brook House to board a flight then use of force can be used. The purpose of use of force is to protect the detainee and others.

169. Specific use of force forms have to be completed following a use of force incident. These are then sent to the Oscar managers.

170. Healthcare see the detainee immediately after the use of force. The detainee has to agree to this, as sometimes they do not want to be seen straight away. Healthcare then follow up an hour after the use of force to complete a second assessment and see if the detainee has suffered any injuries.

171. I have been involved in use of force many times. I have never had to stop a use of force because I was worried about the detainee. All uses of force have been carried out very professionally. I complete use of force documentation and document any injuries that the detainee has suffered.

172. I have witnessed multiple uses of force. I cannot remember specific details, as there have been so many. I always complete a use of force form afterwards.

173. I never had any concerns about the appropriateness of the use of force on detainees.

The Panorama Programme

The Inquiry's website has a link to a YouTube channel which has a BBC Panorama programme available to view for free (BBC Panorama - "Undercover: Britain's Immigration Secrets" - YouTube). If you have not already watched the programme, the Inquiry would ask that you do so and consider the following.

174. I didn't work one to one at any time with Callum Tulley. I used to see him around the centre and recognised his face but I did not have any contact with him.

175. I do not appear in the Panorama footage.

176. The Panorama programme had a huge impact on staff morale. Staff were all very shocked at what they had seen. It was upsetting. Everyone was suffering from very low moods.

177. I cannot really remember the impact the Panorama footage had on detainees, as it was so long ago. A lot of detainees said that they had seen the footage. They were very shocked.

178. I was not involved in the age dispute shown on the Panorama programme. We have a certain protocol that must be followed in age dispute cases. The detainee suspected of being underage must be moved from the wing, away from the adults. Social services must be informed

immediately and a meeting arranged with healthcare, the Oscar managers and the Home Office.

179. More ACDT, mental health and C&R training for officers was introduced following the Panorama programme and there were a lot more searches of staff who were coming and going from the centre.

Specific Individuals

180. I saw Nathan Ring occasionally but did not work closely with him. I had never had any concerns about him from what I did see.

181. I did not know Steve Webb.

182. Chris Donnelly was a Oscar manager. I had no concerns regarding him. He always seemed professional.

183. I did not know Kalvin Sanders.

184. I saw Derek Murphy occasionally but I did not know him very well.

185. John Connolly gave the personal protection training. I never had any concerns about his conduct. I was shocked when I saw him on the programme.

186. I did not know Dave Webb.

187. I did not know Clayton Fraser.

188. I did not know Charles Frances.

189. I did not know Aaron Stokes.

190. I did not know Mark Earl.

191. I did not know Slim Bassoud.

192. I did not know Sean Sayers.

193. I did not know Ryan Bromley.

194. I did not know Daniel Small.

195. I did not know Yan Paschali.

196. I did not know Daniel Lake.

197. I did not know Babatunde Fagbo.

198. I did not know Shayne Munro.

199. Nurse Jo Buss used to supervise me occasionally but she worked mostly in Tinsley House and I was in Brook House. She was always professional and was a good teacher when she was carrying out my supervision. She was very experienced. I never saw anything that concerned me.

Suggestions for Improvements

Part of the Inquiry's remit is to identify learning and make recommendations that would help to prevent the recurrence of such events in the future.

200. I do not have any further suggestions for improvement. I have covered everything within my statement.

Any other Concerns

201. I do not have any other concerns. I have covered everything within my statement.

202. Everyone who was employed at Brook House during the Relevant Period will be knowledgeable of the matters mentioned in my statement.

The topics identified above are not intended to be an exhaustive list and if there are other matters relevant to the Inquiry on which you wish to provide evidence then you should do so.

STATEMENT OF TRUTH

I believe that the facts stated in this Witness Statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in it's truth.

I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.

Signed: Signature Dated: 29/10/21

Name: Havva Daines