BROOK HOUSE INQUIRY

First Witness Statement of Dr Saeed Chaudhary

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 10.7.2021.

I, Dr Saeed Chaudhary, will say as follows:

Introduction

I completed my medical training at King's College Medical School in 2004. I trained in General Practice in 2007 and completed my MRCGP in 2011. I am also an educator, having completed PGCE in 2014. I have been working at Gatwick Immigration Centres, Tinsley House and Brook House, since Feburary 2017 till current.

[Evidence]

I have listed my Evidence in accordance to the Questions asked and written my response below each Question.

1. Your name and date of birth;

Dr Saeed Chaudhary DPA

2. A summary of your career (which explains any professional qualifications which you have, your professional experience and the roles which you have held in your professional capacity including your current role / job description);

I have completed a Batchelor in Science in 2001 and medical training in 2004 from Kings College London, I completed my Membership of the Royal College of General Practitioners in 2011. I completed a Postgraduate Certificate in Medical education in 2014. I have completed the royal college of general Practitioners Substance misuse Level 1 in 2017 and Level 2 in 2020. I have worked as a locum GP in various roles including Community GP, Out of Hours, Care homes, Clinical Commissioning Group. In 2017 I started work with G4S delivering primary care services at Gatwick Immigration removal centres, Tinsley House and Brook house. I also work in Other secure settings including HMP Littlehey and oversea GP services at HMP Whitemoor, HMP Feltham, Yarl'swood Immigration Centre.

Witness Name:	Dr Saeed Chaudhary
Statement No:	[INSERT]
Exhibits:	[INSERT]

3. An explanation of when you worked for G4S Health Services and in what capacity. Include all the roles which you held whilst employed by G4S Health Services and details of your working pattern. If you were not employed directly by G4S Health Services, in what capacity did you work at Brook House?

I have worked for G4S since Feb 2017 until current

4. If you are no longer employed by G4S Health Services, an explanation as to why you left and when.

N/A

Application Process

5. An explanation of what attracted you to working in healthcare at Brook House.

This was an opportunity to further my career both in the context of working with my business partner in venturing into contractual work as well as challenges of working within as an immigration centre doctor, which I had heard a lot about prior to taking up the post.

6. Your opinion of whether the recruitment process prepared you for the role. Please explain your answer.

I came in for a shadow day and was shown around healthcare and had the privilege of seeing healthcare and GP clinics. I attended a rule 35 training day provided by the Home Office and was able to meet other GP's working in immigration setting.

Culture

7. A description of the culture of Brook House when you worked there. In particular, was there an identifiable culture across Brook House as a whole; whether there was a specific culture within the healthcare department or a department, area or wing in which you did not work; if there was, whether it changed over time; in either event, what that culture was.

I was aware of the culture within Healthcare and as I was new to the team I was learning more than contributing at the time, except for medical care. I was not aware of a culture any different to that of the community except being impressed at the relative short waiting times before a patient was seen and that the healthcare team were working well to accommodate residents. I am not aware or able to recall any aspects of care outside of healthcare which made an impact on me at the time.

8. Your views on staff morale at Brook House immediately before, during and subsequent to the Relevant Period, both with regard to healthcare staff and other staff employed at Brook House.

I remember a lot of talk around the panorama documentary coming out. There were mixed views on it. Many saw it as an opportunity to improve care. I was not conscious

of the secure staff morale but healthcare wasn't impacted significantly. Shortly after there was a campaign to speakout which G4S advertised around the centre. I heard people had changed roles and some had left but was not able to match names to staff I may have met, except within healthcare.

9. A description of attitudes towards individuals who were detained at Brook House immediately before, during and immediately after the Relevant Period.

I could not recall major issues prior during and after the relevant period. I cannot recall any secure staff changes after the relevant period except that staff roles had changed and some had left. I believe this is due to the fact that I would spend my time largely with in healthcare and not venture onto the wings unless for emergency patient care. When we would go to CSU or E wing it would be done during locked movements mostly or just prior to this. For this reason I was not in constant sight of secure staff and their interactions with residents.

10. Whether you have any particular concerns about how the values of G4S and / or G4S Health Services or any culture impacted upon the following:
a. The general treatment of individuals who were detained at Brook House;
b. The management of individuals with physical health conditions;
c. The management of individuals with mental health conditions;
d. The management of individuals who could be considered vulnerable;
e. The management of individuals with substance misuse issues;
f. The protection of specific individuals from the type of abuse seen on the Panorama programme.

I had no concerns of the values of G4S healthcare. I am unable to speak of the values of G4S secure.

11. Whether you are aware of any occasions where a member of healthcare staff raised concerns about the treatment of individuals (either individuals or collectively), whether informally or as a "whistleblower" and the response to it and the reaction from detention staff management and healthcare staff management.

I was not aware of any situation

Oversight
12. Set out your understanding of the role of the following bodies, their involvement at Brook House, and the nature of any interaction or communications you had with them.

i. The Independent Monitoring Board (IMB);

I would see them and talk to them and they would ask questions which I would answer. They were present at Quarterly meetings between NHS and G4S where we would be present.

ii. The Gatwick Detainees Welfare Group (GDWG);

I am aware of this group but have little interaction with them

iii. Medical Justice;

We would receive correspondence from them on behalf of residents and respond appropriately. They are an independent organisation.

iv. Bail for Immigration Detainees (BID).

I am not aware of this group or had interactions with them

v. And other external organisations.

No other organisations I can recall.

General Training

13. A description of the general training you received before starting work at Brook House and/or upon starting at work at Brook House. Confirmation of when you attended this training, where it was held and who provided it.

I had an induction and was shown around by healthcare. I spent a day shadowing Dr Oozeerally. I attended a course on Rule 35 provided by the home office. I attended key training on use of keys around the centre.

14. Reflecting on this training, your opinion about whether it prepared you for your role at Brook House. Please explain your answer. If it did not adequately prepare you, please say what else you believe the training should have covered.

I felt adequately prepared for my role.

15. Reflecting on your time in healthcare at Brook House, what training do you consider was necessary in order to fulfil your role?

As a general practitioner the skills acquired prepared me to deal with mental health issues, recognising deterioration and behaviour problems. As for the secure side, I was aware of the emergency responses and adequately informed about officers and their use as well as conflict management with residents.

16. What, if anything could be improved?

I am not sure regarding the secure setting, as for healthcare I felt I was adequately supported and skilled to complete the job of a GP.

17. Whether you were offered, and attended, refresher training courses. If you did, please provide details of the courses. Was there any other training that you think should have been provided on an annual basis?

Possibly Rule 35 refresher courses, I attended RCGP part 1 substance misuse course and then went on to complete my Level 2.

18. Whether you attended any of the training courses provided by G4S to its staff. If so, provide details.

I did not attend any other courses except for Intermediate Life support course.

19. A description of the training you received on the following, including the dates on which you attended such training and any refresher courses on the following matters:

a. Control and restraint (C&R) / use of force on individuals (including both planned and unplanned use of force). Please refer to the Violence Reduction Strategy (CJS000721);

I have not received this training for my role as a GP in Immigration centre

b. Rule 35 assessments and reports; The management of individuals at risk of self-harm or suicide and the ACDT process including the threshold for opening an ACDT document, the management of individuals on an ACDT document and how to complete the documentation. Please refer to the following documents / policies:
(i) Suicide Prevention and Self-harm Management (CJS006380);
(ii) Safeguarding Policy (CJS006379);
(iii) Guidance for staff managing detainees on Constant Observations (CJS006378);
(iv) Management of Adults at Risk in Immigration Detention (CJS000731);
(v) Introduction to Safer Custody, Gatwick IRC's Caring for Detainees at Risk (CJS000052);
(vi) Enhanced Mental Health Training, Gatwick IRCs Caring for Detainees at Risk (CJS000020);
(vii) The management of individuals with substance misuse issues. Please refer to the Drug and Alcohol Strategy (CJS006083);
(viii) Any other specific healthcare training.

I attended a rule 35 training day organised by the Home Office before my post at Brook House. I was informed through my induction and through multiple conversations, with healthcare staff, the process of ACDT documentation and shown how to complete it. The training was not formal. I was made aware and read through policies and SOP's related to healthcare and had accessibility to them when needed including Food and fluid refusal. Since the period in question we have had meetings with the Home Office to discuss around Adults at Risk and the policies.

Staff Induction

20. Please refer to Gatwick IRCs and Cedars Welcome Pack (CJS006391). Provide a description of the induction you received upon starting work at Brook House, including its duration, location, and who provided it.

As stated above I was inducted by another GP who showed me the working day layout and requirements.

21. Did your staff induction process prepare you for your role at Brook House?

It covered the most common aspects and prepared me for the work undertaken.

22. What, if any, problems were there with the staff induction process?

I did not recall any issues at the time.

23. What, if anything, could be improved?

I felt prepared for the role I was going to undertake.

Management of healthcare staff

24. A description of how healthcare was structured in terms of line management and administration during the Relevant Period.

There was the head of healthcare, Practice managers, clinical lead nurses for both Tinsley and Brook House, senior nurses, nurses, HCA's. My line manager was Sandra Calver and Michael Wells who were the Head of Healthcare and Practice manager at the time.

25. Which staff, if any, reported to you as line manager? Please provide both names and roles.

As above

26. Explain your relationship with senior managers in healthcare at Brook House. Include details of the level of contact that you had with them, availability during shift for urgent/non-urgent queries, approachability, and visibility.

We had constant contact with the head of Healthcare and all issues could be brought to her attention for discussion and resolution. She was visible and approachable as were all other staff.

27. Explain your experience of being managed at Brook House. Include details of feedback, appraisals, and working relationship with your direct manager. Provide details of who your direct manager was with dates if recall them.

There were no issues and experience was as I expected with in Healthcare.

28. Set out your experience of working with other healthcare staff, in particular, whether you felt able to rely on other healthcare staff to support you in your role.

Yes I was working alongside nurses and HCA's and my experience and relationships were good. There were no issues.

29. Provide a description of how clinical supervision of healthcare staff generally took place during the Relevant Period.

As GP's we were not clinically supervised except we would run Audits on our work and respond to the HJIPs required and work toward reducing prescribing and referrals in line with good medical practice and community. We had quarterly contract reviews and any issues raised by staff around GP work would be raised through clinical governance meetings and directly as required.

30. Explain how your clinical supervision took place.

As Above

31. Did you experience any problems with your line management or clinical supervision? If so, what?

No issues

32. What, if anything, could be improved?

Things could always be done differently but my experience was that things were measured and done correctly and as I would expect. No improvements I could think of.

Disciplinary and grievance processes
33. Provide details of any involvement you had in disciplinary investigations, including any investigation: (a) carried out by you as a manager; (b) carried out into your own conduct and/or (c) carried out into another member of staff, for which you were a witness.
In relation to each example:
a. please provide approximate dates;
b. a description of the issue;
c. who was subject to the investigation;
d. what the investigation involved;
e. what the outcome of the investigation was;
f. whether any further action was taken following the disciplinary outcome;
g. whether there were any 'lessons learned', and if so, how they were disseminated and followed-up.

There was no disciplinary issues I was involved in at the time.

34. Please provide details of any involvement you had in a grievance investigation, including any grievance investigation: (a) carried out by you as a manager; (b) carried out following a grievance raised against you; (c) carried out following a grievance raised by you; and/or (d) carried out into another member of staff, for which you were a witness.In relation to each example:
a. please provide approximate dates;
b. a description of the issue;
c. who was subject to the grievance;
d. what the investigation involved;
e. what the outcome of the investigation was;
f. whether any further action was taken following the outcome;
g. whether there were any 'lessons learned', and if so, how they were disseminated

There was no grievance issues I was involved with at the time.

Staffing
35. Describe the staffing levels in healthcare at Brook House during the Relevant Period.

Staffing levels were good. There were always nurses and HCA's available and quite a few. It didn't feel understaffed.

36. In your opinion, were there, at all times, sufficient staffing resources to be able to provide adequate healthcare services to the individuals? Provide your opinion on whether the staffing levels in healthcare were of an adequate level to enable staff to perform all the functions of their role. If they were not, identify why not. Further, did you ever raise this at the time. Please provide details. If you did not, please explain why not.

Staffing levels were adequate in my opinion

37. What was the proportion of permanent healthcare staff to agency staff?

I am not sure of the numbers at the time but staff were all regular even Agency staff

38. Were agency staff experienced at working in detention centres or a custodial environment generally?

Yes

39. Were agency staff familiar with the systems and procedures in place at Brook House? What was the nature of training/induction provided, if any?

Yes

40. Did the number of agency staff generally affect the provision of healthcare to individuals? If so, how?

Not in my opinion

41. Provide your opinion on the impact that any shortages (if they existed) had on the care and treatment of individuals, in particular, whether staff were unable to offer services that they would have been able to provide if they were fully staffed (if shortages existed) and if there were delays in provision of healthcare to individuals as a result.

I am not aware of any impact and it appeared services were steady throughout the period in question

42. Provide your opinion on the impact that any staffing shortages had on healthcare staff, including morale and safety (whether perceived or actual).

I am not aware of any impact and it appeared services were steady throughout the period in question

43. Provide your opinion on the staffing levels of the detention staff.

I am not able to comment on this due to not having knowledge around the time in question.

44. Provide your opinion on the staffing levels of the activities team.

I am not able to comment on this due to not having knowledge around the time in question.

Relationship between Healthcare and Detention Staff

45. Provide details of your experience of working with detention staff. In particular:
a. Day to day working with the detention team in relation to the welfare of detained persons ;
b. Effectiveness of involvement of the detention team in use of force incidents;
c. Communication with detention staff about any individuals with ongoing medical needs;
d. Attitude of detention staff towards detained persons (provide any specific examples you are able to recall);

In general relationships were good between healthcare and detention staff. I cannot recall any issues arising at the time. Again, mostly as a GP I was bound to healthcare where patients would come to us to be seen. Detention staff would normally communicate issues with nursing staff. Also GP's were not first responders to emergencies.

46. Did you experience any problems with the relationship between healthcare and detention staff? If so, what?

I did not experience any issues

47. Provide your opinion on the impact any such issues had on healthcare staff, including morale and safety (whether perceived or actual).

N/A

48. Provide your opinion on the impact it had on the ability of healthcare staff to fulfil their roles and to provide adequate healthcare services to individuals?

N/A

49. What, if anything, could be improved?

Unable to comment

Relationship with Home Office

50. Explain your working relationship with Home Office staff, including those who worked within Brook House and those who worked externally. Include details of the level of contact that you had with them, the focus of their involvement at Brook House, your opinion on how they balanced immigration removal procedures with individual welfare. Explain your answer and please give specific details of any particular Home Office staff about whom you wish to comment.

I was new to my role and had communication with Home Office via correspondence mainly. There were no issues surrounding the requests for information and us giving information. They respected confidentiality and questions they asked were sensible and showed concern for welfare, as far as I can remember.

51. Did you experience any problems with the relationship between healthcare staff and the Home Office? If so, what?

There were no issues I was aware of at the time.

52. Provide your opinion on the impact it had on healthcare staff, including morale and safety (whether perceived or actual).

N/A

53. Provide your opinion on the impact it had on the ability of healthcare staff to fulfil their roles and to provide adequate healthcare services to individuals?

N/A

54. What, if anything, could be improved?

N/A

Reception / Healthcare Screening / Induction

55. Please refer to Detainee Reception & Departures (CJS006045) and Detainee Admissions and Departures Brook House IRC (CJS006046). Please provide a description of the usual reception healthcare screening process for individuals on their arrival at Brook House. Please summarise what this involved, for example:
a) How soon it was after arrival;

I was aware it was before 2hrs from arrival

b) Whether it was during daytime or night-time;

I understood it to be both day and night

c) Where it took place;

Downstairs healthcare reception rooms

d) Who carried it out (what level of healthcare professional);

Both Nurses and HCA's

e) Whether the individuals had access to an interpreter if needed/requested;

Yes

f) Whether the individuals were given any written materials concerning healthcare in Brook House;

I believe they were and in their language

g) Whether healthcare staff had access to any previous medical records and if so the process for obtaining them;

Yes if it was already on SystmOne and otherwise we would get consent to request notes from their GP.

h) If an individual arrived with medication in their possession, what the process was for dealing with it;

The GP would write them up on screen. Some medications were given to the patient to continue having in possession.

i) If an individual arrived on medication but without it in their possession, what the process was for the prescription and dispensing of appropriate medication;

We would script it and it would arrive from pharmacy the next working day.

j) If an individual was suffering from a diagnosed physical health condition?

We would document this in the new arrival clinic and assess the patient with in 24hr.

k) If an individual was suffering from a diagnosed mental health condition?

They would be referred to mental health team during reception.

l) If an individual was deemed to be vulnerable?

They would be assessed and a part C would be communicated to Home office.

m) If an individual was assessed as having a substance misuse issue?

There was a 24hr on call and the GP would authorise methadone and prescribe on SystmOne.

n) If an individual was assessed as being at risk of self-harm or suicide?

An ACCT would be opened by healthcare

o) Where the individuals were accommodated for the first night or nights of their stay and what access there was to healthcare staff and services;

There was 24hr nurses on site for any healthcare needs day or night.

p) What provision was there for individuals to healthcare staff to follow up following their first night in detention?

GP new reception clinics were within 24hrs and patients could be booked onto

56. If this usual process was variable, describe how it differed from the description you have provided, how often, why, and in what way.

It was a standard practice

Healthcare Facilities and Equipment

57. A description of the physical environment of healthcare in Brook House. What facilities were there for the provision of the following in Brook House:
a) Primary care services (physical health services);

Nurses and doctors, emergency care, pharmacy technician and medication GP service, dental service.

b) Mental health services.

Psychiatrist and Mental health nurses present

58. Did healthcare have the physical resources to deal with the health conditions with which individuals presented?

I believe so, we would refer as we did in community.

59. Did healthcare have the equipment to deal with the health conditions with which individuals presented?

Yes, As far as I can remember. I didn't feel at any point services were different to the community setting.

60. What problems, if any, were there with the physical environment regarding the provision of healthcare to individuals?

No issues I can think of

61. What problems, if any, were there with equipment regarding the provision of healthcare to individuals?

We had all the equipment suitable for the environment including ECG machine, Emergency equipment and oxygen.

62. What if anything, could be improved?

There is always room for improvement but the standard in my opinion was good.

Access to Healthcare

63. A description of what healthcare services were provided to individuals in Brook House. In particular, please describe the provision for:
i) Primary care (physical health) services;
ii) Mental health services;

See answer 57

64. How would an individual access healthcare? What was the process for an individual to be able to see a:
i) Nurse;

There was a nurse triage and walk-in clinic

ii) GP;

Patient could request to see the GP and have an appointment

iii) Mental health nurse;

Patient could be referred for mental health services and/or attend group sessions run by them.

iv) Psychiatrist/psychologist etc?

This would be referral from the mental health nurse

65. What were the problems, if any, in individuals accessing healthcare?

NO problems as they could come in at any time to be assessed by a nurse.

66. Were there delays in individuals being able to access healthcare? If so, what was the cause of any delays?

NO delays

67. What, if anything, could be improved?

N/A

Detained Persons

68. Provide your views on what the most significant health problems of the detained person population were throughout your employment, focussing on the immediately before, during and after the Relevant period.

Majority of the issues are related to stress and anxiety with musculoskeletal issues playing a part. This was consistent before, during and after the period.

69. What are the challenges that healthcare staff face in managing those health conditions in Brook House?

There are challenges with getting medical history from GP's and also medication lists. Also not knowing when patients will be released means getting treatment sometimes doesn't happen due to sudden release. An example of this is medications or referrals to the hospital.

Interpreters

70. Describe your experience of the use of interpreters in healthcare at Brook House.

The experience is good, there is an interpreter available for the vast majority of consultations.

71. Were interpreters readily available when needed?
In my experience and on the whole, yes.

72. What were the problems, if any, with obtaining interpreters for individuals?

We use Big Word, the issues are around delay in connecting with an interpreter.

73. How did this impact upon the adequacy of the provision of healthcare to individuals in Brook House?

I am not sure if health was impacted except through information lost in translation. On the whole I felt the delivery of care from myself and what I saw from Healthcare largely was equivalent to that in the community and most shortfalls were due to the nature of the centre in which patients would be brought in with little medical information and leave suddenly without complete treatment.

Supported Living Plan

74. What was the purpose of a Supported Living Plan (SLP)?

This was not dealt with by myself with in healthcare

75. In what circumstances would a detained person have a SLP?

This was not dealt with by myself with in healthcare

76. What was healthcare staff's role in a detained person's SLP?

This was not dealt with by myself with in healthcare

Complaints

77. What was the complaints process if an individual had a complaint about healthcare?

They could write to healthcare with any complaint and it would be addressed by healthcare and the relevant team with in healthcare. Complaints about medical care would be answered by myself if it involved a GP.

78. Explain your experience of the complaints process, including, in particular:
i) Any examples in which you received a complaint and referred it on for investigation;

ii) Any examples in which you were involved in an investigation, either conducted by G4S Healthcare or the Professional Standards Unit (PSU), in relation to a complaint made against you or another member of staff.
Please include what happened, any investigation process, the outcome and any lessons learned. If there were lessons learned, whether they were implemented and effective.

Our company DRPA have dealt with around 8 direct complaints from 2017 till current, regarding GP services in which I was involved in 2 complaints. There was an external investigation conducted into one patient's medical treatment which was not upheld. G4S had an external investigator come in to interview myself and another GP regarding the care delivered and processes in general and there it was concluded that complaints regarding the GP care were not upheld.

E Wing
79. Please refer to E Wing Policy (CJS006043). Describe the nature of the detained persons who were accommodated on E Wing.

Ewing residents were detained for various reasons. Healthcare had 2 rooms in which we would allocate patients who needed close monitoring and observation i.e. for substance misuse or unwell or under investigation for TB etc.

80. What was the purpose of accommodating an individual on E Wing?

From healthcare as above. My understanding of other residents was a whole host of reasons including some who were disruptive and others chose to be away from general population and so accommodated in EWING at their own request.

81. What was healthcare's role in the management of individuals on E Wing?

We would go to EWING daily and enquire if anyone wanted to see the GP. In particular we would see those allocated due to medical reasons.

82. Please refer to Removal from Association (CJS006040) and Temporary Confinement (CJS006041). What are the criteria for moving an individual to the Care and Separation Unit (CSU)?

This was not part of my remit as a GP

83. What was healthcare's role in the management of individuals on the CSU?
Medication

Healthcare would deliver medications to those who could not come to healthcare to receive them.

84. A description of the process for management of medication for an individual who had been prescribed medication that could remain in their possession.

Medication would be prescribed for 28 days and then the patient would come to healthcare to receive them.

85. If an individual was prescribed medication that could not remain in their possession what was the process for obtaining required medication?

They would come up to healthcare at allocated times and receive their medication.

86. What were the problems, if any, in the management of detained persons' medication?

These issues would be known to the pharmacy team.

87. What, if anything, could be improved?

I am unable to comment as I do not have oversight of the processes.

Drug / alcohol misuse

88. Please refer to the Drug and Alcohol Strategy (CJS006083). A description of the process for the identification and assessment of individuals with substance misuse issues on their arrival in reception at Brook House.

Patients would be identified in reception screening and a drug test would be completed. if Out of Hours this would be discussed with the on call GP. The patient will be given medications as appropriate and then be transferred to EWING and monitored regularly. At 5 days they would be assessed.

89. What treatment was available at Brook House for individuals identified as having a substance misuse issue?

Methadone, Chlordiazepoxide

90. What substance misuse services were available in Brook House during the Relevant Period?

Forward services for drug and alcohol were present and able to give support to those misusing drugs. There was 24hr nursing available and GP support. Medications were on site.

91. Were the services and treatment available for individuals with substance misuse issues adequate in your view?

Yes as there have been no incidents in the last 4 years.

92. What, if anything, could be improved?

There is always room for improvement but services were adequate and safe in my opinion.

93. A description of the level and nature of substance misuse amongst individuals in Brook House during the Relevant Period.

Mostly patients were on Methadone and the centre policy is to detox them as many are going to countries without substance misuse services or they are limited.

94. What was healthcare staff's role in the management of individuals who were using drugs or alcohol whilst in Brook House?

We would manage any patients thought to be misusing drugs such as spice. We were involved in passing on information or intelligence to the centre. Nurses would respond to any emergencies.

95. What was your experience of attending to individuals who were intoxicated by drugs or alcohol in Brook House?

I have attended to medical emergencies where someone may have a seizure. I would escalate any concern and call an ambulance if required.

96. Did you have any concerns about the appropriateness of healthcare staff's management of individuals who were intoxicated?

No

97. Did you have any concerns about the appropriateness of detention staff management of individuals who were intoxicated?

No

98. If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?

N/A

Mental Health

99. A description of your experience of the management of individuals who suffered from mental health conditions.

They were referred to mental health services and the psychiatrist was in regularly on Friday's to assess any patients requiring their input.

100. Did you have any concerns about the appropriateness of healthcare staff's management of individuals who suffered from mental health conditions?

No

101. Did you have any concerns about the appropriateness of detention staff management of individuals who suffered from mental health conditions?

No

102. If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?

N/A

Rule 35 reports

103. If you were involved in writing Rule 35 reports, please set out your experience of doing so.

I attended a Rule 35 training session with Home office prior to post and also shadowed a doctor on how to write the report.

104. Set out your understanding of the purpose of a Rule 35 report?

To highlight any medical or mental health aspect that would make a patient unsuitable for detention.

105. Describe the approach taken when assessing an individual in accordance with Rule 35 and recording that assessment.

A patient would be given an appointment to see the GP and they would be assessed in accordance with the rules of the report.

106. What criteria are applied to identify suitability for ongoing detention?

Is the patient deteriorating either mentally or physically. Has the patient been tortured in the past.

107. What is the nature of an assessment of an individual for the purposes of a Rule 35 report? How is the assessment carried out?

The patient is assessed for physical scars and mental health involvement and then their general state with in detention to determine if they are suitable for detention.

108. Who was responsible for ensuring compliance with clinical standards and the effective implementation of the Rules 33-35 of the Detention Centre Rules (DCR) safeguards?

Home Office and G4S healthcare

109. What are the challenges you face or faced in carrying out Rule 35 assessments? What, if any, problems were there?

There are overwhelming claims of torture and so majority of rule 35's pertain to this. There was not a standard provided by the Home Office that we were able to reference. I would compare my reports to other clinicians and an audit was completed looking at Rule 35's. This Audit was conducted by G4S healthcare. We are aware our decision in the report is not complied with due to other factors regarding the resident's immigration/prior prison sentences.

110. Did you have any concerns about the process of assessment and writing of Rule 35 reports?

As there were many factors involved it was my responsibility to complete the form to the best of my ability and keeping a true and accurate statement of what I was being informed by the resident.

111. If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?

We did speak about this with the home office, regarding the processes of Rule 35 and what was required. i.e. what constituted torture.

112. What, if anything could be improved?

Having clearer indication on what constitutes a successful rule 35 report and what doesn't qualify. The definition of torture is very inclusive of majority of scenarios.

ACDT and self-harm risk management

113. Please refer to the following documents / policies:
i) Suicide Prevention and Self-harm Management (CJS006380);
ii) Safeguarding Policy (CJS006379);
iii) Guidance for staff managing detainees on Constant Observations (CJS006378);
iv) Management of Adults at Risk in Immigration Detention (CJS000731).
A description of your role and involvement, if any, within the ACDT process

I would initiate an ACDT to be opened and documented in ACDT records.

114. A description of how individuals who were at risk of self-harm or suicide were identified and assessed.

Staff would report issues to mental health or healthcare would inform mental health through a referral process. ACDT would be opened by wing staff or healthcare. Mental health were automatically involved with the ACDT reviews, in my understanding.

115. What role did healthcare staff play in the identification and assessment of detained persons who were at risk of self-harm or suicide?

As above

116. What role did healthcare staff play in the management of individuals who were at risk of self-harm or suicide?

As a GP we may be involved in prescribing medications, we would assess the individual as appropriate to check for deterioration and communicate anything worrying to the home office as a Part C. We were to assess and see suitability for a Rule 35 after 7 days.

117. Did you have any concerns about the appropriateness of healthcare staff's management of individuals who were at risk of self-harm or suicide?

No

118. Did you have any concerns about the appropriateness of detention staff management of individuals who were at risk of self-harm or suicide?

After the panorama I was appalled at the behaviour of some of the detention staff in those with mental health issues. However at the time I was not aware of this behaviour as I was not present on the wings due to being in healthcare mainly. Patients did not communicate complaints about mishandling of staff members during consultations.

119. If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?

As above

ACDT
120. What do you understand the purpose of an ACDT document to be?
121. When would an ACDT document be opened in relation to an individual?
122. What was the threshold for opening an ACDT document?
123. What was the process for opening an ACDT document?
124. How would an individual be managed on an ACDT document?
125. What was the review process for individuals with an open ACDT document?
126. When would an ACDT document be closed in relation to an individual?
127. How could an ACDT be challenged?
128. What role did healthcare staff play in the management of individuals on an ACDT document?
129. What problems were there, if any, with the process of managing individuals on ACDT documents?
130. What, if anything, could be improved?

My involvement in ACDT was the occasional opening of one due to statement of suicidal ideation. The vast majority was opened on the wing or by Nurses (as they would be offering the triage services prior to GP appointments being made). I was

aware of mental health involvement and we would discuss any worrying patients on a day to day basis. I would write in the ACDT documents if I saw a patient to check on their progress. The purpose of an ACDT is to ensure any patients with a risk of self-harm are cared for by staff from all areas. I believe the thresholds were low for opening one. Any statement of suicidal intent was considered enough for opening an ACDT, in my experience. Mostly the reviews and the closing of ACDT did not involve the GP. We did however see the patients to provide our independent review of their medical and mental health condition and discuss this with the mental health team as appropriate especially during our MDT meeting.

131. The inquiry understands that there were weekly healthcare Multi-Disciplinary Team (MDT) meetings held attended by the mental health team, medical team (GP) and healthcare administration team. Did you attend these meetings? What was their purpose and what was discussed?

Yes, the purpose was to discuss all patients of concern. Any one from healthcare or mental health could put patients on the list for discussion.

132. The Inquiry understands that there were Safer Community Meetings and Adults at Risk (AAR) Meetings held in Brook House attended by detention staff. Did healthcare staff attend these meetings? If not, why not?

Yes we attended an AAR meeting at Brook hose with the home office to discuss new changes to the definition of torture and also the AAR policies.

133. Were there any mechanisms in place to offer support or counselling to individuals who had witnessed a violent or distressing event at Brook House?

The mental health team were involved in counselling as were the chaplaincy teams.

Food and Fluid Refusal

134. Please refer to the Refer to Food & Fluid policy (CJS006084). What was healthcare staff's role in assessing an individual who was refusing food or fluids?

Anyone noted to be on Food and Fluid refusal would be reported to healthcare and reviewed daily. GP's would be informed and the patient assessed as appropriate for any deterioration. Those on fluid restriction would be assessed quicker by the GP than those on food alone.

135. What was healthcare staff's role in managing an individual who was refusing food or fluids?

Nurses would assess the patient daily. I would speak to the individual and explore the reasons. The patient was invited with the home office present to sign an advanced directive of their refusal. This included what the patient would like healthcare to provide for them, should they become too unwell.

136. What documentation did healthcare staff need to complete where an individual was refusing food or fluids?

From a GP point of view it was documenting in the notes and an advanced directive.

137. Have you had experience of individuals refusing food or fluids? If so, please describe your experience.

Yes, I have experienced this a lot. Mostly the pressures of not knowing when they will fly, coupled with issues form the country they are being deported to leads them to refusal in the hope they will be listened to and released.

138. Did you have any concerns about the appropriateness of the management of individuals who refused food or fluids? If so, did you raise any concerns? If so, who did you raise concerns with? If not, why not?

There was no concerns with the management. On a couple of occasions I was concerned for the patient as they were severely dehydrated. When I gave this information in a Part C to the home office, they released the individual.

Use of Force

139. Please refer to the Violence Reduction Strategy (CJS000721). What role do healthcare staff play in the use of force on a detained person individual?

I believe healthcare were present during any CNR's taking place.

140. In what circumstances is it permitted to use force on an individual?

This was not dealt with by myself with in healthcare

141. What records are required to be completed by healthcare staff following a use of force against an individual?

This was nurse led and GP's were not involved in this aspect of care.

142. What follow up is carried out by healthcare staff on an detained person following a use of force?

Nurses would assess the patient and at times as a GP I was asked to see the patient for any injuries. I documented this and treated any medical issues.

143. Have you ever been involved in the use of force on an individual? If so, please give details. What documentation did you complete afterwards?

No

144. Have you ever witnessed the use of force on a detained person? If so, please give details. What documentation did you complete afterwards?

I was present on a few occasions. The level of force and reason for use felt appropriate. I was with a nurse and the documentation was filled out by the nurse.

145. Did you have any concerns about the appropriateness of the use of force on the individual? If so, did you raise any concerns? If so, who did you raise concerns with? If you did not do so, why not?

As above

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.

146. Confirmation as to whether you worked with Callum Tulley (the BBC undercover reporter). If you did, please set out details of when you worked with him.

No

147. Whether you appear in the programme. If you do, please confirm the timings on the footage where you appear. It would be helpful if you are able to provide a photograph or description of yourself so that the Inquiry is able easily to identify you.

I do not appear

148. Your opinion on the impact that the Panorama programme (which aired on 4 September 2017) had on staff morale.

I believe there was a low morale with detention staff and also with in healthcare in relation to Jo Buss who we all knew. However, many of us were of the opinion that if this is happening it is not right and that the panorama programme will force a change for the better of the residents. I was not negative about the programme. Any bad practices or culture should not exist and I felt strongly I didn't t want to work in a centre that exhibits these behaviours. Things had changed afterwards. However healthcare towards patients has remained the same in my opinion and good medical care is delivered which is equivalent to that in the community.

149. To the extent that you are aware of individuals seeing or become aware of the Panorama programme (e.g. the media), your opinion on the impact that the Panorama programme had on individuals.

I am not sure if I noticed the impact as the Panorama programme came out around 6months after working at Brook House. I was not working every day and mostly in my clinic. I remember healthcare talking about it and Jo having been mentioned. Disciplinary action and suspension of staff had occurred quickly and morale was low but also a positive feeling for change.

150. During the programme, one detained person says that they are underage for detention.
151. Whether you were involved in this (or any other age dispute) case. An explanation of the process to be followed.

Age dispute is communicated to the home office to verify. I would assess the patient but ultimately unable to confirm or deny their age unless there are medical distinctions. If I feel they are underage I would offer express this with evidence in apart C to the home office.

152. Whether there were any changes at Brook House following the Panorama programme and your opinion on whether they were effective. If they were not, your opinion on what should have been done to create effective change.

There were changes I believe. I felt that the stay of residents was less. I felt that officers were more careful. Body worn cameras, I think, were introduced. Many of the faces I would see were changed either they left or roles were changed.

Specific Individuals

153. The following individuals who worked at Brook House were either investigated, disciplined, dismissed or left following the Panorama programme:
a. Nathan Ring
b. Steve Webb
c. Chris Donnelly
d. Kalvin Sanders
e. Derek Murphy
f. John Connolly
g. Dave Webb
h. Clayton Fraser
i. Charles Frances
j. Aaron Stokes
k. Mark Earl
l. Slim Bassoud
m. Sean Sayers
n. Ryan Bromley
o. Daniel Small
p. Yan Paschali
q. Daniel Lake
r. Babatunde Fagbo
s. Shayne Munro / Munroe

t. Nurse Jo Buss

I only worked with Jo Buss. I have no recollection of the other individuals by name. Of course I would have seen them around the centre but not have been involved in interactions of a significant clinical nature.

With regards to Jo Buss, she was the clinical lead nurse for Tinsley House which I believe the PDA was undergoing refurbishment. She was excited in overseeing this and appeared to be caring for those that might stay and proud of the facilities. I cannot remember any incident which I felt she was not caring or any practices which were negative towards residents.

In relation to each of these individuals, set out the following:
i. Whether you worked with these individuals. If so, provide details of when you worked together, your working relationship and your opinion of them in a professional capacity. If you had concerns about their personal views/behaviours and that this impacted on their care of individuals, please set these out.
ii. Whether you witnessed them use derogatory, offensive and/or insensitive remarks about individuals. If so, provide details of what they said, the reaction of the individual, what you did (if anything) and the outcome.
iii. Whether you witnessed any incidents of verbal abuse. If so, provide details of what they said, the reaction of the individual, what you did (if anything) and the outcome.
iv. Whether you witnessed any incidents of physical abuse. If so, provide details of what they said, the reaction of the individual, what you did (if anything) and the outcome.

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.

154. Where not specifically covered above, set out your opinion of what could be changed or improved at Brook House in order to improve individual health, safety and welfare.

I don't feel I have the capacity to comment as I do not have sight of all the processes with in brook house. As always, more training and awareness would help.

Any experience by a former detainee to new staff would offer different insights to staff especially experiences around mental health. I am not sure if this is already being done.

Any other Concerns

155. To the extent not covered by the above, please mention or explain any other matter which relates to the culture of G4S at Brook House, and the treatment of detained persons which you consider may be relevant to the Inquiry. In

particular, the Inquiry would welcome any information that you have (this need not be limited to information that you have direct knowledge of) concerning whether in relation to any of the above topics there have been any significant changes such that the situation in Brook House is different now to the situation in 2017.

The 'wind rush' issues and Covid 19 has seen a significant drop in the number of residents passing through Brook house. I believe this has had an impact.

156. A list of names of individuals working at Brook House who you believe are knowledgeable about the matters that you have mentioned in your statement.

Dr Husein Oozeerally
Head of Healthcare – Sandra Calver

157. Any further matters which you consider relevant to the Inquiry's work.

No

Second set of Questions

Training
1. At paragraphs 6 and 13 your Draft Statement, you state that you attended a rule 35 training
day provided by the Home Office. At paragraph 17, you state you possibly attended rule 35
refresher courses.

No, my statement of 'Possibly Rule 35 refresher courses' was to the question 'Was there any other training that you think should have been provided on an annual basis?'
To make it clear I was not offered or attended refresher training courses on Rule 35 at the time as we had one in early 2017.

a. Please provide dates for these training days/courses;
The date was in Early 2017 around January for the Rule 35 training day.

b. Please explain what the training entailed on each occasion, what topics were covered, how the training was delivered, what materials were used, how long the training lasted, and who delivered the training (their role/job title and experience);
It was a full day training that had GP's and Home office explaining about Rule 35 and how to complete them. There were examples of Rule 35's and how to complete them and what to look out for in victims of torture.

c. Please set out how often you received such training.

Only Once

2. At paragraph 14 of your Draft Statement, you state that you felt adequately prepared for
your role with the training received. Please explain your answer.
I felt able to conduct Rule 35 reports and understood their purpose.

3. Reflecting on your training and refresher training courses, please set out any other training
that you think should have been provided on an annual basis.

Rule 35 training should have been offered annually. I thought this was the case having attended the Rule 35 day in January 2017. There was no other Rule 35 training day I was aware of in 2018. In 2019 there was a Rule 35 and Adults at Risk meeting where the new definition of torture was explained as well as the Adults at Risk policies.

Culture

4. At paragraph 7 of your Draft Statement, you state, "I was aware of the culture within Healthcare". Please explain this statement. In particular, please describe the "culture within
Healthcare" during the Relevant Period and comment on whether it changed over time.

The culture with in healthcare was to put patients first and advocating for them. I was aware of this culture only as I was with in this environment when at Brook house as opposed to te culture amongst Officers or Home Office.

5. Please describe staff morale at Brook House Healthcare prior to, and during, the Relevant
Period (before knowledge of the Panorama documentary). Please address staff morale of Healthcare staff and other staff employed at Brook House.

Staff morale was good. I can't recall any issues prior or during the period. I Started working at Brook house in February 2017.

6. Did you, or do you, have any particular concerns about how the values and/or culture of
G4S and G4S Health Services impacted upon the following:
a. The general treatment of individuals who were detained at Brook House;
b. The management of individuals with physical health conditions;
c. The management of individuals with mental health conditions;
d. The management of individuals who could be considered vulnerable;
e. The management of individuals with substance misuse issues;
f. The protection of specific individuals from the type of abuse seen on the Panorama Programme.

I was not clinically concerned

Management of healthcare staff
7. Did any Healthcare staff report to you as line manager? If so, please provide their name(s)
and role(s).

I was the line manager along with Husein for Dr Catherine Eades during the period in question.

8. In relation to your experience of being managed at Brook House, at paragraph 27 of your
Draft Statement you state, "There were no issues and experience was as I expected with in
Healthcare." Please explain your answer, including details of feedback, appraisals, and your working relationship with your direct manager.

My Direct manager was Michael Wells (Practice manager) and Sandra Calver (Head of healthcare) along with Peter Kolowaski (line manager to Sandra Calver). I had a good relationship with them all and they were able to discuss any issues to me directly if they felt the need.

9. At paragraph 29 of your Draft Statement, you refer to quarterly contract reviews taking
place. Please set out:
a. Whether you attended these reviews and, if so, what your role was;

Either myself or Dr Husein Oozeerally would attend along with a lot of other professionals including Home office and G4S, Substance misuse and NHS England. There were two meetings. One was the Gatwick IRC partnership meeting and the other was the Quarterly Quality Committee Meetings and included healthcare Governance.

b. When these reviews were set up, and whether they still take place;

Yes they still take place.

c. The purpose of these reviews;
Gatwick IRC Partnership Board – To look at issues arising in the centre and working together between Home Office, Secure and Healthcare.
Quality Committee meetings - To assess the healthcare contract and delivery of services including Audits, complaints and incidents.

d. Your view as to whether the reviews fulfilled their purpose;
Yes they did

e. What actions were taken as result of these reviews;
Minutes have been taken and you may have requested them. I am unable to comment due to not being able to recall specific details. The minutes should

reveal the conversations taken place. In particular, for us as GP's, were the discussion around Rule 35 waiting times and appointment times
f. Whether such actions was effective;
As in e) Above

g. If there were any lessons learned from these reviews, whether they were implemented and/or effective.
As in e) Above

10. At paragraph 29 of your Draft Statement, you state, "…any issues raised by staff around
GP work would be raised through clinical governance meetings and directly as required." Please set out:
a. Whether you attended these meetings and, if so, what your role was;
We are invited and attend Staff meetings and the Quarterly Quality Clinical Governance meetings. Mostly any issues with GPs would be communicated to us at the staff meeting or directly afterwards. We could also be approached directly any day We also had a Contract review meeting with Michael wells (Practice manager) and Sandra Calver (Head of Healthcare)
b. When these meetings were set up, and whether they still take place;
They still take place
c. The purpose of the meetings;
All these meetings are to improve patient care and open official communication of issues
d. Your view as to whether the meetings fulfilled their purpose.
Yes I believe they did.
e. What specific issues staff raised around GP work during the Relevant Period;
Minutes have been taken and you may have requested them. I am unable to comment due to not being able to recall specific details.
f. What, if any, action was taken in response to each issue and whether this was effective;
As in e) Above
g. If there were any lessons learned, and whether they were implemented and/or Effective.

As in e) Above

11. Did you attend any other meetings or committees of this nature? If so, please set out:
No
a. The name of the meeting or committee and usual attendees;
b. Your role in the meeting or committee;
c. When it was set up and whether it is still operating;
d. The purpose of the meeting or committee;
e. Your view as to whether the meeting or committee fulfilled its purpose;
f. What actions the meeting or committee took;
g. Whether such actions were effective;

h. If there were any lessons learned, and whether they were implemented and/or effective.

Healthcare facilities and equipment

12. At paragraph 62 of your Draft Statement, when asked what if anything could be improved
[in respect of healthcare facilities, provision and equipment], you state, "There is always room for improvement but the standard in my opinion was good." Please explain your answer and describe where, in particular, there was room for improvement and why.

This is a general statement and means that through Auditing and Quality Improvement Activities any service should be improving and enhancing with time. The service at the time was good.

Complaints

13. At paragraph 78 of your Draft Statement, you state that you have been involved in two
complaints. In respect of both complaints, please explain:

a. What the complaint was about;

b. Whether the complaint was made against you or another member of staff;

c. The nature of the investigation process, if any, and who conducted it (whether it was G4S Healthcare or the Professional Standards Unit (PSU));

d. The outcome;

e. any lessons learned, and comment on whether they were implemented and/or effective.

The complaints were outside of the Period in Question. One complaint occurred from an incident on 1.11.2019 where a patient was upset due to a discussion around reducing pain medications. The complaint was not upheld and no further complaint occurred.

The second complaint occurred from an incident on 4.12.2019 where a patient complained about a Rule 35 not being completed by myself. The events he disclosed made me feel the Rule 35 criteria was not met. A part C communication of the events was sent to the home office to consider and give opinion. The patient was given a second opinion and a Rule 35 was completed a week later.

Substance misuse services

14. At paragraph 92 of your Draft Statement, when asked what if anything could be improved
[about the services and treatments available for individuals with substance misuse issues], you state, "There is always room for improvement but services were adequate and safe in
my opinion." Please explain your answer and describe where, in particular, there was room
for improvement and why.

This is a general statement and means that through Auditing and Quality Improvement Activities any service should be improving and enhancing with time. The service at the time was good and safe.

Mental health
15. Please consider by way of examples CJS001967 and CJS002002, which are mental health
referral forms that you completed, in relation to two detained persons. Please explain:
a. The circumstances in which you would make a mental health referral;

Any patient that I professionally deemed to benefit from a mental health assessment through seeing the mental health team.

b. The process for making mental health referrals;

Filling in a referral form to the mental health team.

c. Your role following making a referral of a detained person following a mental health Referral.
The patient would be assessed by the mental health nurse and psychiatrist if needed. I would then offer help by way of prescribing medications that may be needed.

Rule 35
16. Please see the attached table at Annex A listing rule 35 reports that you completed during
the Relevant Period. Please review those documents.
a. Please explain why in each of the rule 35 reports included at Annex A (except for HOM002582) section 7 is not completed, i.e. the reports do not contain your name as the assessing doctor or your signature.

All Rule 35 documents were signed and a copy kept in the healthcare office. These signed copies were then emailed to Home Office. The signed copy would be scanned into the patient's records.

b. Do you accept authoring each of the rule 35 reports included at Annex A? If not, please explain the reasons and state which report(s) you say you did not author, and who you understand to have authored them.

Yes.

c. Save for HOM0332027, pages 2-8, the rule 35 reports included at Annex A relate to concerns regarding torture and are therefore reports under rule 35(3).
i. Please explain why that is the case;
The patients wanted to talk about torture they had experienced.

ii. Please explain why so few reports were completed in relation to concerns

about the health impact of continued detention (under rule 35(1));
The majority of patients were able to be managed within healthcare at the time. Early communication to Home Office, usually in a part C may have them released before the time it would take to have an appointment for a rule 35. This pathway was usually quicker and more appropriate.
My understanding at the time was that patients were not entering the immigration centre if their health was deemed unfit for detention. This was due to the fact that the gate keepers for detention (from amongst the Home office) would not recommend them for detention. This was my understanding.

iii. Please explain why no reports were completed in relation to concerns about suicidal intentions (under rule 35(2)). If you did complete such reports during the Relevant Period, please provide copies.

The vast majority of reports were in relation to claims of torture. Reports of suicidal intention required for an ACDT to be opened and mental health involvement. Part C's and communication to the home office were undertaken. The majority of these cases had an element of torture in the patients history and as a result a part C on torture claims would have been completed which would include a mental health component. The Rule 35 (2) form requires answering question which include reducing risk through ACDT and also Mental health assessments. These would be the first steps for any patient who had suicidal ideation. If Patients were not improving through these interventions then a rule 35 (2) would be completed.

d. Please see CJS007075, which is the Home Office Detention Services Order 09/2019 Detention centre rule 35 and Short-term Holding Facility rule 32. This guidance makes clear that the assessment at section 6 should include, "The impact
7
detention is having on the detainee and why, including the likely impact of ongoing detention." Please explain the reasons the rule 35 reports at Annex A do not contain an assessment of the impact detention on the detained person including the likely impact of ongoing detention as required by the guidance.

I recorded positive findings, at the time of assessment I felt the patient was not deteriorating in detention and left this comment out. If I felt a patient was deteriorating then I would include this in the assessment. Home Office had opportunity to feedback if they felt any short coming in the assessment and when they did then I would respond. This was my practice at the time.

17. Please consider CJS0073839, which is the Rule 35(2) Pathway. Please set out:
a. What the document is and how it was used;
b. When it was in force;
c. Whether there was further guidance on the pathway. If so, provide details;
d. How you were aware of it;
e. How staff (including Healthcare staff and detention staff) would have been aware of it;

f. Whether there was any training provided on the pathway;
g. Any other comment you wish to make on the pathway.

This was a G4S policy which came into effect around the end of 2019. I understood the pathway as explained to me.

Specific detained persons
D668
Please consider:
• HOM002582: Rule 35(3) report regarding D668 dated 24 July 2017;
• DL0000040: D668's medical records;
• HOM002578: Letter from the Home Office to D668 dated 25 July 2017;
• HOM002748: PSU report dated 21 February 2018;
• HOM002539, pages 29-30: The relevant pages of the summary of the PSU's interview with D668 dated 20 December 2017;
• HOM002564: Summary of the PSU interview with you dated 18 January 2018;
• DL0000153, pages 5-6: The relevant pages of D668's first witness statement to the Inquiry dated 22 November 2021;
• INQ000100, pages 2, and 12-16: Brook House Inquiry Phase 2 Hearing live evidence transcript for day 10.
18. Confirm whether the summary of your PSU interview (HOM002564) accurately represents
the account you gave. If not, please explain why and add anything that you wish to add to
the account.

Yes this is accurate at the time.

19. The entry of 24 July 2017 at 13:48 in D668's medical record (DL0000040, pages 40-41)
relates to the rule 35 assessment you conducted. Please explain:

a. How long the rule 35 appointment with D668 lasted;

Each appointment is given 45 minutes and varies in length. I am not sure of the exact time it had taken to conduct this Rule 35.

b. How you would describe your demeanour in the interview;

I am impartial and professional.

c. How you would describe the manner in which you asked questions of D668 in order to obtain his account and/or any relevant information for your assessment and report.

I am unsure of what this means. I ask questions and write a report.

20. Section 5 of the rule 35(3) report asked for "relevant clinical observations and findings" and
listed what was required. You only mentioned D668's scars in the report. Please explain the

reasons you did not address D668's medical history as was required, even if it was to note
that you had no concerns.

The scars were an aspect of his account. His medical history prior to the Rule 35 assessment on 24th July 2017 did not include any significant medical conditions. He arrived at brook house on 28th June 2017.

21. Section 6 of the rule 35(3) report asked for your "reasoned assessment of why, on the basis
of the detainee's account together with his own examination and clinical findings, he was concerned that the detainee may have been a victim of torture." There was a list of areas to
address including "impact detention is having on the detainee and why, including the likely
impact of ongoing detention." Please explain, in each case, the reasons why your report did
not address the specified matters.

As reported in HOM002748

22. In your interview with the PSU, you suggested that you did not provide an assessment of
the impact of detention because you did not have any concerns.

a. If that was the case, explain why you did not state this in the report.

As reported in HOM002748

b. Confirm whether you ever reached a view about whether detention had a negative impact on D668. If so, set out how, if at all, this was communicated.

He was under the mental health team and appeared to be engaging with the team in their emotional wellbeing group. There were a few appointment he missed with the GP. He was advised also to apply to be transferred to Tinsley house. No other communication from me to the Home office regarding detention having a negative impact on this patient was made.

c. Did the Home Office take any steps to follow up with you what you considered to be the impact of detention, and the likely impact of continued detention, on D668, given it was not recorded as was required in the rule 35 report? If so, provide details.

No correspondence regarding this was sent.

23. Please see HOM002748, page 36, which is the PSU report dated 21 February 2018. At
paragraph 7.5.11 the report states, "I found that Dr Chaudhary's assessment of D668 under
Rule 35 was incomplete. It was unfair for Dr Chaudhary to assume that by not stating the
impact of detention that as assumption of no impact would be made by the [Home Office]

caseowner."

a. Please comment on these conclusions;

My understanding was that if further clarity was required on the Rule 35 this would have been communicated to me via the home office.

b. Please confirm whether you received a copy of this report at the time, or were made aware of its findings and conclusions;

I believe I did not personally receive the report from the home office.

c. Please set out what, if any, action you took in response to this conclusion;
d. Please set out what, if any, action was taken against you in response to this conclusion;
e. Please set out what, if any, lessons were learned as a result;
f. Please set out any changes you made to your practice as a result.

Rule 35's are now conducted differently and I now include all negative and positive findings in the reports. This has been a result of quality improvement exercises with G4S as well as feedback from the Home office and following the interview HOM002748. Peer reviewed Rule 35's have taken place informally with in our GP team by Dr Oozeerally and Myself and fed back to GPs as appropriate.

24. At paragraph 8.10.10 of HOM002748, the PSU set out the required action, "Detention
Services should review DSO 11/2014 and then clarify with NHS England what is expected
of their staff. Once agreed, they should communicate to their respective staff who is responsible for these assessments on the scarring and in relation to the torture account and
whether there would be an impact on that detainee remaining in detention."
Please confirm whether:

a. You were aware of Detention Services carrying out such a review;

I cannot recall this as a specific event except we attended an adults at Risk meeting.

b. NHS England communicated with Healthcare at Brook House, Dr PA Ltd, or with you, what was expected of GPs carrying out rule 35 assessments and reports. If so, provide details;

G4S did conduct a Rule 35 Audit

c. There was any change in the approach to rule 35 reports following this PSU report.
Rule 35's are now conducted differently and I now include all negative and positive findings in the reports. This has been a result of quality improvement exercises with G4S and peer reviewed Rule 35 assessments as well as feedback from the Home office and following the interview HOM002748.

25. Please see DL0000040, which is D668's medical records. At page 40, the records indicate
that he returned to see you on 28 July 2017. The relevant entry states that he mentioned depression, a sleeping problem, that he was having nightmares and that he would like to start anti-depressant medication, which you then prescribed.

a. Confirm whether D668 returned to speak to you about the rule 35(3) report being incomplete. If so, provide details.
I cannot recall this happening
b. Explain your approach to the discussion with D668 about the rule 35 report being incomplete.

I cannot recall this happening

c. Please see INQ000100, which is the transcript for Day 10 of the Brook House Inquiry Phase 1 hearings. At page 14, in his evidence about that occasion, D668 stated that you said to him, "you know that I know you can cope". Do you accept saying this to him? If so, please explain what you meant and your reasons for saying it.

I cannot recall this happening and do not accept I would say words in this way.

26. Please provide any additional comments on the account provided by D668 in his:
a. PSU interview (HOM002539);
b. First witness statement to the Inquiry (DL0000153);
c. Live evidence to the Inquiry (INQ000100).
No further comments

27. Please see DL0000040. These records indicate that after completing the rule 35 report on
D668, you saw him again on 28 July 2017 (at page 40), 7 August 2017 (at pages 37-38), 10 August 2017 (at page 37), 23 August 2017 (at page 36), 6 September 2017 (at page 34-35), and 21 September 2017 (at page 33).
a. Confirm whether you reviewed D668's medical history on each occasion.
I would have reviewed relevant aspects of his medical notes relating to his presenting complaint.
b. Set out any concerns you has about the impact of detention on D668 in light of his documented mental health concerns and suicidal thoughts.
He was under the mental health team at the time and being reviewed by them regularly. An ACDT was not opened for the patient at the time.
b. Please provide any further comment on these consultations.

No further comment

D1713
28. Please consider BHM000005 at pages 3-14 (D1713's patient record), and at pages 6-9 (D1713's witness statement). The entry of 1 April 2017 at 11:22 (see pages 4-5) indicates

that you saw D1713 that day. He mentioned that he was having flashbacks of his childhood
and had been for some time, he was scared to look in the mirror, he was having thoughts of
self-harm, he had scars from cuts on his face and back, and he felt scared. You advised an
urgent mental health assessment and prescribed Sensitive/Irrelevant. In light of what D1713 reported
to you:
a. Set out the questions that you asked him including any in relation to mental health, his flashbacks, his scarring, or whether he had been tortured. Explain why you asked him these questions and/or omitted others.

Assessments on the same day would be a Rule 34 appointment and this would have been to review the patients medical history and write up medications. On reviewing this patient it was clear he needed a mental health assessment and I ensured it was done the same day. The patient was informed and I started him on anti-depressants which are helpful with symptoms of flashbacks. Following this an ACDT was opened and it showed improvement in his condition. It has been documented he was not suicidal. My primary focus was to have a mental health assessment done on the same day for this patient.

c. Did you examine D1713's scars? If not, explain why.

It was not common practice to examine the scars unless they were recent as this would have been assessed in a rule 35 separately.
c. Did you have any concerns about the impact of detention on D1713? If so, set them out and explain why they were not documented.

I was concerned about the impact of detention and so a referral to mental health team was made where by an ACDT was opened and my understanding was that this process would open communication with the home Office. If the patient was deteriorating despite mental health involvement and medication then a Rule 35 (1 or 2) report would have been triggered. On 4.4.2017 it was documented he had no suicidal thoughts and on 10.4.2017 it was documented he was cheerful and talkative with no signs of low mood.

d. Please explain why you did not complete a rule 35 report under either rule 35(1), rule 35(3) or both.

Rule 35's were allocated to specific appointments laid out during the week. He may have been added to the Rule 35 appointment and have a set day in which they would be completed.

29. At page 5, the entry of 1 April 2017 at 11:40 confirms that you requested an immediate
mental health referral and that a mental health nurse saw D1713 that evening. Set out any
involvement you had with D1713 after you made this referral.

The mental health team would discuss back any concerns they would have. He was receiving the appropriate care with in healthcare.

30. At page 7, the entry of 8 April 2017 at 14:37 indicates that you subsequently saw D1713 in
relation to Sensitive/Irrelevant. His medical records show that since you saw him on the morning of 1
April 2017:
• He had been placed on ACDT;
• He had disclosed to the mental health nurse physical abuse by his uncle in Nigeria including being beaten and burnt; he showed the nurse physical marks sustained as a result of the abuse; he said he was having flashbacks of these experiences;
• He was continuing to see the mental health nurse.

a. Did you review D1713's medical history when you saw him on 8 April?

I saw the patient with regards to his presenting complaint during the consultation. He was under the mental health team and had an open ACDT.

b. Set out the questions that you asked him including any in relation to mental health, his flashbacks, his scarring, or whether he had been tortured. Explain why you asked him these questions and/or omitted others.

These were already recorded in the notes from his mental health assessment. A diagnosis of PTSD would need an assessment from a Psychiatrist who was working as part of the mental health team.

c. Confirm whether you had any concerns about his mental health and history of torture in light of previous entries? If so, set them out and explain why they were not documented.

He was still under the mental health team and his records indicate he was improving.

d. Did you have any concerns about the impact of detention on D1713? If so, set them out and explain why they were not documented.

An ACDT was already open Home Office were aware of his condition. With intervention ithrough medication and Mental health reviews it appeared from his records that his condition was improving.

e. Please explain why you did not complete a rule 35 report under either rule 35(1), rule 35(3) or both.

Rule 35 appointments were allocated daily at specific times. I am not sure if he had an allocated appointment for a Rule 35 (3). Rule 35 (1) would have been completed if his records indicated he was deteriorating despite interventions.

31. D1713 says it was not until 6 May 2017 at Harmondsworth that he was asked questions for
the first time about torture experienced in Nigeria, which resulted in a rule 35(3) report

being prepared. Please explain the reasons no rule 35 report was completed whilst D1713
was at Brook House.

I am not sure if he had an appointment for a rule 35 torture claim. He may have been discharged prior to his appointment for Rule 35 happening.

D1914
32. Please see CJS001068, which is a facsimile dated 19 April 2017 from you. You confirm that
you consider D1914 is fit to travel and fit to be detained. Please see HOM010916, which is
a Home Office IS.91RA Part C - Supplementary Information Form regarding D1914 dated
13 July 2017. This records your conclusion that D1914 was not fit to fly or fit to be detained.
You note that he "has multiple health issues which although initially stable are now at risk of
worsening due to detention. He has been to healthcare increasingly more due to his cardiac
symptoms and I feel he is at risk of further cardiac issues should he have prolonged time in
detention." D1914's medical history during the Relevant Period is at CJS007200. Please set out:
a. Details of the assessment that you carry out when considering whether someone was fit to fly in general, and specifically on each occasion you saw D1914;

I use the Civil Aviation authority guidance for fitness to fly. CJS001068 is a response to a Home Office Query which would have asked if the patient was fit to fly and fit to be detained.

b. Whether you were aware of previous assessments by other clinicians as to whether someone was fit to fly in general, and specifically in this case. If so, explain how, if at all, you took it into account;

Fitness to fly assessment is for the time the assessment is made and provided their health remains the same, may be used shortly past the date it is written. I was not aware of previous assessments by other clinicians.

c. the criteria that you applied as to whether someone was fit to fly in general, and specifically in this case;

Looking at past medical history and current medical history to determine if there would be any risk to their health on flying. Using the criteria from Civil aviation authority

d. any assessment that you carried out when considering whether someone was fit for detention in general, and specifically in this case;

If someone is deemed to be deteriorating in their health and their demand on healthcare is increasing This would trigger an assessment. If their mental health is worsening and is not showing improvement or their needs are not being met with in the immigration setting then this would also require an assessment.

e. the criteria that you applied as to whether someone was fit for detention in general, and specifically in this case;

In this case it was the history of CABG and 3 x MI which if stable makes him fit for detention. If it is at risk of destabilising due to detention then this would make him unsuitable for detention. With time he was presenting more to healthcare with chest pains. I was concerned

f. Whether you were aware of previous assessments by other clinicians as to whether someone was fit to be detained in general, and specifically in this case. If so, explain how, if at all, you took it into account;

I am not sure if I had seen any previous statements regarding this patient. In general I have seen other clinicians statements as to whether a patient is fit to be detained or fit to fly and they are similar to mine.

g. The circumstances in which a Part C (such as at HOM010916) would generally be Completed.

Any concern that I would have and felt needed to be communicated to the home office would be documented and sent in a part C.

33. Please see CJS007200, which is D1914's medical records. At page 25, the entry of 25 July
2017 at 15:18 indicates that you saw D1914 after a rule 35 report was submitted to the Home Office. The Inquiry has a copy of a rule 35(1) report dated 17 July 2017 signed by Dr
Oozeerally. Please set out your role, if any, in D1914's rule 35 assessment and report.
D313
I had discussed this case with Dr Oozeerally and the nurse and informed the Home office immediately. A Rule 35 (1) was completed later. I have not received the rule 35 to review its contents recently.

34. Please see CJS001048, which is D313's medical records. At page 27, the entry dated 9 June 2017 records a facsimile message from you stating that D313 was fit to fly and fit to be detained. Please set out:
a. the assessment that you carried out when considering whether D313 was fit to fly;

Assessment of his medical records as documented in the reception screening and up until the date of the fitness to fly letter.

b. Whether you were aware of previous assessments made by other clinicians as to whether he was fit to fly. If so, explain how, if at all, you took it into account;

I cannot recall being aware.

c. the criteria that you applied as to whether D313 was fit to fly;

This was based on his medical history and following guidance from civil aviation Authority.

d. the assessment that you carried out when considering whether D313 was fit to be detained;

Assessment of his medical records as documented in the reception screening and up until the date of the fitness to be detained letter.

e. Whether you were aware of previous assessments made by other clinicians as to whether he was fit to be detained. If so, explain how, if at all, you took it into account;

I cannot recall being aware.

f. the criteria that you applied as to whether D313 was fit to be detained.
This was based on his health care needs being able to be met at Brook House at the time the report was written.

35. Please see HOM030801, which is Dr Lisa Wootton's expert psychiatric report concerning
D313, dated 25 May 2017. Were you aware of the contents of this report when making your
assessment as to D313's fitness to fly and fitness to be detained?
a. If yes:
i. At page 19, in relation to fitness for detention, Dr Wootton notes the increased risk of suicide and self-harm for D313 in detention. Did you take this into account in your assessment? If yes, why does you facsimile message at CJS001048, page 7 not address it? If no, why not?
ii. At page 20, in relation to fitness to fly, Dr Wootton states, "I note the acute exacerbation of his mental health and an increased risk of self-harm and suicide and appropriate supports and protection should be in place to try and manage this… If these support mechanisms are not in place there is a real risk of self-harm or suicide attempt". Did you take this into account in your assessment? If yes, why does your facsimile at CJS001048, page 27 not address it? If no, why not?

I cannot recall having seen the document. The fax is a direct response to home office query and summarises my conclusions based on his medical history at hand. My understanding is that the reports are sent to the Home Office who

would be aware. He did not have an ACDT document open. He was not on mental health medications.

b. If no, did you have access to D313's medical records, including medical records from prior to his arrival at Brook House? Did you review these records as part of your assessment?

I cannot recall whether I did or didn't. Usually there would be no medical records and this would need to be requested and may take some time to be faxed over form their GP surgeries.

c. Please address the following:
i. At page 2 of CJS001048, the entry of 30 May 2017 at 19:54 states D313 had been prescribed anti-depressants. Set out any concerns you had in light of this and whether you took it into account during your assessment. If you did, explain why your facsimile at page 27 not address it. If not, explain why.

I was not asked to explain my conclusions by the home office but to give my medical opinion. My understanding is that Anti depressant medications are not a contraindication to flying and being detained.

ii. Were you aware of the medical history set out at paragraphs 14 to 19 of Dr Wootton's report (insofar as it is taken from the medical records), in particular D313's diagnosis of depression and mixed anxiety, his history of self-harm and suicide attempts and extended periods on an ACDT whilst in custody? Set out any concerns you had in light of this and whether you took it into account during your assessment. If you did, explain why your facsimile at page 27 not address it. If not, explain why.
I was not aware of the report at the time. I was not asked to explain my conclusions by the home office but to give my medical opinion with the medical information I had at the time.

d. If you did not have access to D313's medical records, please explain how you were properly able to reach the conclusion that D313 was fit to be detained and fit to fly.

My assessment was based on medical conditions that prevent a patient from flying by the Civil Aviation Authority and his medical assessments in his records.

Use of force
36. At paragraph 144 of your Draft Statement, you state that you were present on a few occasions when force was used on a detained person. In relation to each occasion, please
set out:
a. The approximate dates;
b. The detained person(s) against whom force was used;
c. The staff member(s) involved;
d. The reasons force was used / circumstances in which force was used;

e. The reasons you were present;
f. Whether you considered the force used was reasonable and proportionate;
g. Whether you held any concerns about the use of force from a Healthcare perspective. If so, what action you took as a result.

I was present along side the nurse. It was not my role to assess the use of force nor was I trained to do this. I went along to further my knowledge of the process. I received no training in this.

37. Please refer to CJS007047, which is the policy document "Monitoring a Patient During and
After Restraint", issued in August 2016 and reviewed in December 2018. This policy details
the timing and manner of monitoring of patients subject to restraint, to help reduce the risk
of death, injury or illness.
a. Please set out the extent to which you were aware of this policy and its contents during your time working at Brook House. In particular, please explain whether this policy was:
i. drawn to your attention whilst you were working at Brook House;
ii. used by you and/or other healthcare staff during Control & Restraint incidents.
b. Please provide your opinion on how useful this policy was and whether it took into account the realities of working at Brook House. Explain your answer.
I was not required to be present during use of force so was not required to undertake this policy and its contents. Nurses would assess patients after a CNR and there would be a debrief with officers and nurse. I attended to further my knowledge of the process.

c. If it did not, please explain what, in fact, happened and any differences between policy/procedure and practice.

I am unable to comment on this.

38. On occasion, you examined detained persons who had been subject to Use of Force or
restraint. For example, please consider CJS002331 at page 32; CJS002741 (regarding D191); HOM003765 at page 4 (regarding D3548); CJS007170 and CJS007171 (regarding D1103). In each case, the examination was not carried out immediately after the Use of Force or restraint but in the days that followed. Please set out:
a. Whether you were told about the reason for the Use of Force and given a summary of what happened;
CJS002331, HOM003765, - not present.
I was not always informed and my assessment was of the injuries the patients had rather than what happened during CNR. Nurses would be present during the CNR and I believed there was a process with protocols governing this.

i. If yes, provide details.

b. Whether you considered, generally and specifically in these examples, whether the injuries reported by the detained persons raised any concern that force may have been inappropriate, excessive or disproportionate;

I was not directly involved in the CNR process.

i. If yes, provide details and the outcome.
39. In relation to D191, you recorded seeing him on E wing, and that he had a bruised eye and
that he "injured himself with a remote control" (see CJS002331 at page 32). This was the day after the Use of Force by officers (see CJS002741 at page 23).
a. Were you aware that D191 had been subject to the Use of Force the previous day? If yes, explain why you did not record this in your notes. If not, explain why you were not aware.
b. Set out how you concluded that D191 had "injured himself".
c. Paragraph 7.1.30 of the PSU report into the incident (see CJS002741 at page 23) states that the medical notes in the F213 record that D191 knocked his face on a table in the room and there was swelling to his right eye but no open wound. Did you have sight of this before or when examining D191?
d. Provide details of the examination process including any account given by D191 and why this is not recorded in your notes.

Statements would be taken from the patients directly as to what has happened and then an assessment undertaken. The entry in the medical notes is a reflection of my understanding from the patient.

40. In relation to D3548, you recorded on 9 March 2017 that he "claims pain in the testicles
from when he was to fly out and was restrained by officers" and he is "not in intense pain or
problems urinating etc" (see HOM003765 at page 4). An earlier entry indicates that the restraint took place on 7 March 2017.

a. When examining D3548, did you obtain an account of what happened to him during the restraint? If yes, explain why you did not record this in your notes. If not, explain why you were not aware.

The use of force is not governed by the GPs and rules around use of force is managed by the Secure provider. In general, statements would be taken from the patients as to their claims and recorded in relation to their clinical presentation.

b. Confirm whether you considered and/or carried out any follow up examination.

41. In relation to D1103, you saw him on 17 April 2017 (see CJS007170), 18 April 2017 and 19
April 2017 (see CJS007171), in relation to complaints of pains in joints and a bruise on his
left arm sustained during the Use of Force. Dr Oozeerally also saw him on 15 April 2017

(see CJS007170), in relation to his left elbow hurting due to the Use of Force. The Use of
Force incident took place on 14 April 2017.
a. When examining D1103, did you obtain an account of what happened to him during the Use of Force? If yes, explain why you did not record this in your notes. If not, explain why you were not aware.

The exact details of the restraint were not required for my assessment. It is understood the areas injured occurred during the restraint as documented on 15th April.

b. Given D1103's was still seeking assistance from Healthcare four days after the Use of Force, confirm whether you had any concerns about the incident. If so, provide details of any action that you took and the outcome. If you did not take any action, explain why.

Objectively the examination did not reveal a fracture or a medical investigation. Simple analgesia would be required.

Suggestions for improvements
42. At paragraph 154 of your Draft Statement, when asked for your opinion on what could be
changed or improved at Brook House in order to improve individual health, safety and welfare, you state, "As always, more training and awareness would help." Please explain your answer and specify the areas in which training and awareness would provide improvements or positive changes.

Training and awareness are terms used to indicate progress and improvement and any training of processes and clinical awareness would improve ongoing patient care.

Post-Panorama
43. Please provide details of any changes in practice from 2017 to date in relation to the following areas:
a. The management of vulnerable detained persons, including those at risk of selfharm, suicide, and victims of torture, and in particular, the ACDT process, the Adults at Risk policy and guidance, the process under rules 34 and 35 of the Detention Centre Rules;
Following the shaw report there were many recommendations that were taken on board by healthcare at the time.
We included weekly MDT meetings to include patients in detention for long period of time.
Any member of healthcare could add to this list if there was any patient of concern and we discussed this between mental health, nurses, hca, pharmacy and GP's.
We attended an Adults at risk meeting with the Home Office to explain the processes.

Rule 34's were completed the same and Rule 35's have improved from auditing and peer review.
G4S have implemented a police on ACDT and Rule 35 assessments.
We introduced a 1 % audit of clinician documentation
We introduced internal appraisal for our staff
I was appraised by G4S Clinical director

b. The management of detained persons with substance misuse issues;
An Audit on Day 5 reviews an COWS scoring has improved the management of patients with Substance misuse.
c. The management of detained persons who refuse food and fluids;
This has been managed by nurses and GP's would be involved when clinically indicated.
d. Involvement of Healthcare staff in use of force incidents;
Not able to comment.
e. The management of detained persons under rules 40 and 42 of the Detention Centre Rules.
Not able to comment.

2019 Clinical Review

44. Please see CJS007078, which is the Clinical Review for the purpose of an Independent
Investigation of Gatwick Cluster IRC dated 22 March 2019 (Dr Linsell's Report). Dr Linsell's report concerns his independent investigation into Dr Frank Arnold's (Clinical Director, Forrest Medico-Legal Services) allegations about perceived risks to the physical and mental health wellbeing of detained persons held in the Gatwick cluster Immigration
Removal Centre (IRC's). This was specifically Brook House, Tinsley House and Yarl's Wood, where G4S provides healthcare services.
Please explain your involvement in this investigation and Dr Linsell's Report.

I was interviewed along with Dr Oozeerally on the complaints made by Dr Arnold.

45. One of the primary concerns Mr Arnold raised was that G4S Healthcare policy prevented doctors from consulting or communicating between one another, directly contributing to the isolation and potential institutionalisation of clinicians employed by G4S.

I did not find this statement to be true at Brook house and Tinsley House. Myself, Dr Oozeerally and Dr Eades would communicate effectively about any patients of concern.

Please comment on this.
46. Please consider pages 8-10, 20-22, 30-32, and 39 of Dr Linsell's Report. In Case 2 (00802)
(see page 20, paragraph 6.2), Dr Linsell concluded that Dr Oozeerally missed an

opportunity to diagnose PTSD and that certain clinical records were inadequate. At page 22, Dr Linsell noted that he spoke to you and that you were "a little surprised that the focus
of Dr Arnold's concerns seemed to be more about Dr Oozeerally's clinical practise than [your] own". Please explain the reasons for your surprise.

I shared equal time at Brook house and Tinsley house as Dr Oozeerally yet his concerns seemed to be heavily biased towards Dr Oozeerally. I was surprised as I thought there would be an equal share as based

Please provide any further comment on this statement.
47. Please consider pages 12-14, 23-24, 33-35, and 40 of Dr Linsell's Report. In relation to
Case 4 (00891) (see page 33, paragraph 7.4.1), Dr Linsell expressed concern that Dr Arnold and you and Dr Oozeerally might have different approaches to rule 35 examinations.
For example, in relation to the examination for scars, Dr Linsell refers to your examination
for the same as "incomplete". Dr Linsell goes on to state, "Normally, if these three doctors
trusted each other, they could 'get in to a room' and resolve such matters without the need
of others to get involved" and he was "concerned about there being a pattern of concerns
being raised but resolution of those concerns not being achieved". Please:
a. Comment on these conclusions;

I was not asked to attend any meeting with Dr Arnold. I had heard of Dr Arnold and don't recall having any dealings with him except through this complaint. I respect Dr Lindsells opinions.

b. Confirm whether you were informed of these concerns at the time of the report;
c. Set out what, if any, action you took in response to these concerns;
d. Set out what, if any, action was taken against you in response to these concerns;
e. Any lessons learned as a result of these conclusions;
f. Any changes in your clinical practice as a result.

I cannot recall being informed specifically about having a meeting with Dr Arnold but as part of the generality of Dr Lindsells report I accepted and appreciated his investigation and comments.

48. Please consider pages 21, 31, and 43-44 of Dr Linsell's Report. At page 31, Dr Linsell notes that Sandra Calver agreed that there was a "wide variety in the amount of information
contained in doctors' rule 35 reports" and that she had taken reasonable managerial action
to address this, but had not achieved success thus far. Please set out:
a. Whether you accept that there was a "wide variety in the amount of information

contained" in rule 35 reports. Please provide any further comment in relation to the amount of information contained in your rule 35 reports;

Information would vary dependent on the patient's narrative of events and their mental health at the time. I would agree that there was no uniform way amongst doctors of completing the form. This was evident from the Rule 35 day with the Home Office in Jan 2017 from conversations with other clinicians present on that day. An example was that some would complete a Body Map and others would not and both were acceptable. The narrative in Rule 35 assessments also varied but I believe this is largely due to the recollection from patients.

b. Whether Sandra Calver or anyone else took managerial action towards you to try and address this issue. Please set out details of such action, your response and the outcome;
We did have an audit of our rule 35's of all GP's at Brook house.

c. Whether you are aware of Sandra Calver or anyone else taking any managerial action towards any other GP working at Brook House to address this issue. Please set out details of such action, the response and the outcome;

No specific actions.

d. Whether there was any change in the approach to rule 35s following this review generally, by you or any other GP.

In general Rule 35 information has improved with time and experience as stated previously

49. Please consider pages 14-16, 24-25, 35-36, and 40 of Dr Linsell's report. In Case 5 (00840)
(page 14, paragraph 5.5), Dr Linsell raises concerns about the adequacy of Dr Oozeerally's
rule 35 report certifying the detained person as being fit to be detained and fit to fly. In relation to the rule 35 report, Dr Linsell notes that it was unsigned and there was no consideration of the detained person's mental health. A visiting independent psychiatrist later assessed the detained person to be suffering from PTSD and severe depression and you said you never saw this psychiatric report.
a. Please comment on these conclusions;

I believe all Rule 35 would be signed. If I did not see the report I am unable to comment.

b. Please comment on whether you consider that there is/was a pattern of rule 35 reports being left unsigned, at least from the Relevant Period until 2018.

Rule 35 reports were always signed as I understand that Home Office would reply back if they were not.

50. Following Dr Lindsell's Report, please explain what actions you took, what actions were
taken towards you. Was any disciplinary or other action taken against you following the concerns raised about your practice? If so, provide details.

No actions were taken against me.

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 its 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.	
Name	Dr Saeed Chaudhary
Signature	**Signature**
Date	10/2/2022