

<p>1 Monday, 14 March 2022</p> <p>2 (10.00 am)</p> <p>3 (Proceedings delayed)</p> <p>4 (10.14 am)</p> <p>5 MS SIMCOCK: Chair, the first witness this morning is</p> <p>6 Dr Rachel Bingham.</p> <p>7 DR RACHEL BINGHAM (affirmed)</p> <p>8 Examination by MS SIMCOCK</p> <p>9 MS SIMCOCK: Can you give your full name, please?</p> <p>10 A. Dr Rachel Bingham.</p> <p>11 Q. What are your qualifications?</p> <p>12 A. I'm a GP. I obtained my qualification as a doctor in</p> <p>13 2009 from King's College London School of Medicine, from</p> <p>14 where I also had a Masters in Philosophy of Mental</p> <p>15 Disorder. I went on to complete my training as a GP at</p> <p>16 University College Hospital London, getting my MRCGP or</p> <p>17 Member of the Royal College of General Practitioners, in</p> <p>18 2015. Alongside my training as a GP, I have developed</p> <p>19 my interest in the medical care of asylum seekers and</p> <p>20 refugees through training at Freedom from Torture and</p> <p>21 Medical Justice in assessment of survivors of torture</p> <p>22 and ill-treatment using the Istanbul Protocol, and</p> <p>23 I have supported that with diplomas in medical care of</p> <p>24 conflict and catastrophe, forensic medical science and</p> <p>25 in public health.</p> <p>Page 1</p>	<p>1 experience to be able to volunteer for Medical Justice.</p> <p>2 Just explain that?</p> <p>3 A. So for medical doctors, we require them to be three</p> <p>4 years post their foundation training, so that's five</p> <p>5 years post qualification. For GPs, that normally means</p> <p>6 qualification as a GP or equivalent relevant clinical</p> <p>7 experience.</p> <p>8 Q. Medical Justice provides training for the role of</p> <p>9 volunteer doctor. Just summarise what that training</p> <p>10 involves for me?</p> <p>11 A. So we do a basic training, which is some home or remote</p> <p>12 learning to work through some modules in assessment of</p> <p>13 mental health in detention, assessment of scarring, and</p> <p>14 in self-care, and then we support that with</p> <p>15 a face-to-face, one-day training which goes back over</p> <p>16 those topics, introduces people to some of the legal</p> <p>17 aspects and policy aspects of immigration detention, and</p> <p>18 then focuses on medical aspects of assessment of people</p> <p>19 in detention. That's our basic training. And then,</p> <p>20 having done that, we pair up new volunteer doctors with</p> <p>21 experienced doctors to observe assessments taking place,</p> <p>22 and they do that as much as they need to, depending on</p> <p>23 their prior experience and expertise, before perhaps</p> <p>24 doing a joint or observed assessment with an experienced</p> <p>25 doctor. Again, until they feel confident and competent</p> <p>Page 3</p>
<p>1 Q. Your role is the clinical advisor to Medical Justice; is</p> <p>2 that right? What does that role entail?</p> <p>3 A. That's right. As clinical advisor, I provide clinical</p> <p>4 technical support to our team of caseworkers, for</p> <p>5 example, answering medical queries or looking at medical</p> <p>6 records in our cases. I do casework myself, seeing</p> <p>7 clients and writing medico-legal reports, doing medical</p> <p>8 assessments, and I provide support and training to our</p> <p>9 network of about 65 volunteer doctors.</p> <p>10 Q. In a nutshell, what does Medical Justice do as an</p> <p>11 organisation?</p> <p>12 A. Medical Justice provides support and help to people who</p> <p>13 have medical problems in immigration detention or have</p> <p>14 medical needs, including a need for medical evidence in</p> <p>15 their asylum case and, as an organisation,</p> <p>16 Medical Justice provides clinical evidence and case work</p> <p>17 and policy work relating to immigration detention.</p> <p>18 Q. Medical Justice has a number of volunteer doctors. You</p> <p>19 say in your statement they are mostly GPs. But do they</p> <p>20 also comprise other disciplines as well?</p> <p>21 A. Yes, that's right. They are mostly GPs, but we have</p> <p>22 doctors from a range of specialties, from surgical,</p> <p>23 medical specialties and a number of mental health</p> <p>24 specialists, psychiatrists and psychologists.</p> <p>25 Q. You say that they have to have a certain amount of</p> <p>Page 2</p>	<p>1 to be able to do that role themselves.</p> <p>2 Q. There is a particular process for the completion of</p> <p>3 medico-legal reports at Medical Justice. Again, just</p> <p>4 summarise what that is for me?</p> <p>5 A. That's right. So the medico-legal report is done in,</p> <p>6 normally, a face-to-face or, since Covid, sometimes an</p> <p>7 online consultation between the doctor and the client.</p> <p>8 That's usually at least a 90-minute assessment. If</p> <p>9 there is a need for interpreting or a longer assessment,</p> <p>10 it could be several hours of a one-to-one assessment</p> <p>11 of -- if it is a general GP, it might be an assessment</p> <p>12 of their mental health and of any scarring. After that,</p> <p>13 the doctor writes a report which details their clinical</p> <p>14 findings, reviews the person's medical documents, looks</p> <p>15 at, for example, immigration detention centre medical</p> <p>16 records in detail, and, putting all that together, forms</p> <p>17 their opinion, and the questions they would likely cover</p> <p>18 would be about the consistency of the presentation with</p> <p>19 the person's account. So the extent to which the</p> <p>20 findings are evidence of torture or ill-treatment that</p> <p>21 the person has reported in their asylum case.</p> <p>22 There might be other questions they would cover too,</p> <p>23 but often focus on that. Having produced their report</p> <p>24 in draft, that report goes to a caseworker and</p> <p>25 a clinical reviewer, who is an experienced doctor, for</p> <p>Page 4</p>

<p>1 a clinical review, which is a peer review, really, but</p> <p>2 by an experienced clinician. We have a small team, just</p> <p>3 six experienced doctors, who read all of the reports at</p> <p>4 that stage so that helps us to provide some quality</p> <p>5 assurance and ensure a consistent standard for our</p> <p>6 reports.</p> <p>7 Then, after that, the report would be finalised with</p> <p>8 the doctor.</p> <p>9 Q. For the purposes of giving evidence to the inquiry, you</p> <p>10 prepared a statement, and it is at <BHM000033>. I am</p> <p>11 going to take you to some parts of that statement and,</p> <p>12 in particular, to the case studies that you have</p> <p>13 analysed in preparing that statement. I am not going to</p> <p>14 take you to absolutely everything in it, because I will</p> <p>15 ask that the statement in its entirety is adduced into</p> <p>16 evidence. What that means is that it stands as your</p> <p>17 evidence, so I don't need to ask you about every single</p> <p>18 line in it.</p> <p>19 In relation to the case studies you have looked at,</p> <p>20 you have been able to analyse those and identify various</p> <p>21 themes arising out of them. How many case studies did</p> <p>22 you look at?</p> <p>23 A. Sorry, I don't have the answer off the top of my head,</p> <p>24 but at least 90 rule 35 reports plus the six detailed</p> <p>25 case studies I have appended to my statement.</p> <p style="text-align: center;">Page 5</p>	<p>1 subsequently assessed him, but also didn't explore those</p> <p>2 symptoms further, and he was under the care of</p> <p>3 the mental health team for two months, but no-one from</p> <p>4 healthcare undertook any specific investigation into his</p> <p>5 trauma symptoms. He was then referred to</p> <p>6 Medical Justice. He was diagnosed by one of your</p> <p>7 psychiatrists to have PTSD and to have been adversely</p> <p>8 affected by his detention and, following that report</p> <p>9 being produced by Medical Justice, he was granted bail.</p> <p>10 What sort of failures do you consider that this case</p> <p>11 illustrates?</p> <p>12 A. Thank you. I think this case is a fairly typical</p> <p>13 example of the types of failures that we have been</p> <p>14 highlighting. So starting with the rule 35 assessment,</p> <p>15 which, as you say, was an assessment to document his</p> <p>16 history of torture and any associated features, in this</p> <p>17 case, the individual has said that he has flashbacks and</p> <p>18 fear in episodes, and the doctor has noted that these</p> <p>19 are not very often and the person is saying they manage</p> <p>20 them themselves. They have gone on to conclude he's</p> <p>21 been referred to the mental health team, and the only</p> <p>22 mention of mental health issues in the concluding</p> <p>23 sections of the report, which is essentially the summary</p> <p>24 of the advice to the Home Office about the person's</p> <p>25 condition, just says "some low mood" and referred to the</p> <p style="text-align: center;">Page 7</p>
<p>1 Q. I want to look at, then, various of the themes that came</p> <p>2 out of those case studies that you deal with in your</p> <p>3 witness statement. The first one you identify is</p> <p>4 a failure to recognise symptoms of mental health</p> <p>5 problems in IRCs. In particular, you refer to PTSD and</p> <p>6 depressive disorders. At paragraph 61(b) of your</p> <p>7 statement, which is at pages 21 and 22 -- your statement</p> <p>8 should be in the bundle in front of you at tab 1, if you</p> <p>9 need to refer to it.</p> <p>10 A. Thank you.</p> <p>11 Q. You look at the case of D1525 and, again, you should</p> <p>12 have a cipher list in front of you. We are referring to</p> <p>13 the detained persons by their D number --</p> <p>14 A. Yes.</p> <p>15 Q. -- and not their name, and for reasons that will be</p> <p>16 obvious to you. D1525 disclosed to a nurse that he had</p> <p>17 been kidnapped, beaten and had scars on his back and arm</p> <p>18 and that he suffered flashbacks, and a rule 35</p> <p>19 assessment carried out subsequent to this disclosure</p> <p>20 documented his account of torture and trauma-related</p> <p>21 symptoms of flashbacks, anxiety and fear. Although the</p> <p>22 GP concluded that D1525 may be a victim of torture, he</p> <p>23 didn't make any comment on D1525's mental health, even</p> <p>24 though there were those apparent trauma-related symptoms</p> <p>25 present. He was seen by a mental health nurse who</p> <p style="text-align: center;">Page 6</p>	<p>1 mental health team. So the implication is, this person</p> <p>2 can be managed in detention.</p> <p>3 But, actually, looking at the bigger picture, we</p> <p>4 have got somebody who has given a history of torture and</p> <p>5 is now giving a clinically plausible account of</p> <p>6 flashbacks and episodes of fear which are clearly</p> <p>7 features of PTSD, so they're clearly symptoms related to</p> <p>8 a history of torture. So that should be recognised and</p> <p>9 flagged up. Why is that particularly relevant here?</p> <p>10 Well, because a person who has given an account of</p> <p>11 torture is now in detention, which is an environment</p> <p>12 that is known to trigger and exacerbate exactly these</p> <p>13 types of symptoms. So these are the most relevant</p> <p>14 symptoms to identify in this context. What does it mean</p> <p>15 to miss that? Well, it means leaving the person in</p> <p>16 a situation where those symptoms will be exacerbated,</p> <p>17 and that's really a source of extreme distress and</p> <p>18 suffering, because flashbacks being exacerbated, it's</p> <p>19 not just a symptom that, you know, happens in passing.</p> <p>20 That's a reexperiencing of torture. So what's happening</p> <p>21 in the person's experience there is going to be as if</p> <p>22 they are being tortured again. So it's really</p> <p>23 important, from a clinical perspective, that a risk of</p> <p>24 that symptom being exacerbated, which we know to be</p> <p>25 a risk in this environment, is picked up and flagged up,</p> <p style="text-align: center;">Page 8</p>

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<p>1 but was missed in this case. As in many cases we</p> <p>2 continue to see, this person then went on to stay in</p> <p>3 detention until one of the Medical Justice doctors</p> <p>4 picked up and diagnosed the PTSD, and we can see that</p> <p>5 that did lead to the person being released.</p> <p>6 Q. To his release?</p> <p>7 A. Yes.</p> <p>8 Q. Do you have a view as to the reasons for these types of</p> <p>9 failures occurring, particularly given that the rule 35</p> <p>10 forms themselves direct consideration of mental health</p> <p>11 symptoms, don't they?</p> <p>12 A. Yes, that's right. One of the questions in the final</p> <p>13 section is to specifically consider if there's a risk of</p> <p>14 deterioration in that environment and one of the other</p> <p>15 questions is to highlight psychological consequences of</p> <p>16 the ill-treatment the person describes. So there is the</p> <p>17 direction there in the form, and yet we repeatedly see</p> <p>18 that that is missed. The reasons, I think, for missing</p> <p>19 this safeguard, it's not, therefore, that there's a lack</p> <p>20 of clarity in the form that needs to be filled in, but</p> <p>21 it's that it's not done. So to answer that question,</p> <p>22 I think we need to look at a bigger picture of systemic</p> <p>23 failures to implement these safeguards and to fully</p> <p>24 understand their importance.</p> <p>25 Q. Would training help?</p> <p style="text-align: center;">Page 9</p>	<p>1 Q. He also had a past history of self-harm and ongoing</p> <p>2 self-harm, which you say also increases the risk of</p> <p>3 suicide. So not just previous suicide attempts, but</p> <p>4 other acts of self-harm are also an indication of a high</p> <p>5 risk of suicide?</p> <p>6 A. Absolutely, yes.</p> <p>7 Q. He expressed hopelessness and possible auditory</p> <p>8 hallucinations. In addition, he was recorded to state</p> <p>9 suicidal intent. So he was making a disclosure that he</p> <p>10 intended to commit suicide. None of this information</p> <p>11 appeared to have been drawn together by anyone, you</p> <p>12 comment, in healthcare to recognise and communicate that</p> <p>13 he was someone at high risk of harm and deterioration in</p> <p>14 detention. The relevant mechanism for managing risk of</p> <p>15 self-harm and suicide appears to be the ACDT. Would you</p> <p>16 agree with that?</p> <p>17 A. I think ACDT is what's used to manage these risks, yes.</p> <p>18 Q. What is the problem with the ACDT system in management</p> <p>19 of self-harm and risk of suicide?</p> <p>20 A. So ACDT is not a clinical -- it is not a clinical tool.</p> <p>21 So it is not a therapeutic or a clinical response. It</p> <p>22 is more of a management response for behaviours that are</p> <p>23 problematic and difficult to manage in a secure</p> <p>24 environment. So it doesn't address at all the</p> <p>25 underlying causes. It doesn't provide any sort of</p> <p style="text-align: center;">Page 11</p>
<p>1 A. I think training is important, but, as I say, the</p> <p>2 information is there. So we think that there are</p> <p>3 systemic failures in a bigger picture of why these</p> <p>4 things are not being implemented. I think, as has been</p> <p>5 described elsewhere, the clinicians are working in an</p> <p>6 environment which is not conducive to recognition of</p> <p>7 the symptoms. First of all, there needs to be</p> <p>8 a disclosure, so the clinicians need to be perceived as</p> <p>9 independent and able to advocate for the patients, and</p> <p>10 then, when there's a disclosure, that needs to be</p> <p>11 recognised and acted on by the clinicians. But,</p> <p>12 actually, we think that there are many systemic and</p> <p>13 environmental factors that mean that those steps don't</p> <p>14 happen.</p> <p>15 Q. I want to look at the case of D1527 next, please, and</p> <p>16 your statement comments that this case illustrates</p> <p>17 a number of different concerns or failures in the</p> <p>18 system. We are relatively familiar with the case of</p> <p>19 D1527 now, given the evidence to the inquiry. His</p> <p>20 medical records contained multiple indications that he</p> <p>21 was at risk of suicide. On arrival at Brook House, he</p> <p>22 was already on an ACDT. He had a past history of</p> <p>23 suicide attempts. You say that that's a strong</p> <p>24 predictor of future risk; is that right?</p> <p>25 A. Absolutely, yes.</p> <p style="text-align: center;">Page 10</p>	<p>1 treatment or therapeutic intervention to alleviate the</p> <p>2 person's distress or to improve the symptoms of their</p> <p>3 mental health.</p> <p>4 Q. So is it an adequate response to the risks presented by</p> <p>5 someone who's presenting with self-harm or suicidal</p> <p>6 intent?</p> <p>7 A. No, I think, for those reasons, it's an entirely</p> <p>8 inadequate response. I would also refer to</p> <p>9 Dr Brodie Paterson's statement, who has explained that</p> <p>10 ACDT is a prison-style response, not at all suited to</p> <p>11 clinical presentations in immigration detention.</p> <p>12 Because it doesn't address the underlying psychological</p> <p>13 symptoms, because it doesn't relieve distress and</p> <p>14 because it doesn't provide any therapeutic input, it is</p> <p>15 not only an inadequate response to those things, it is</p> <p>16 just not a response to them.</p> <p>17 Q. It also doesn't appear to either automatically, or</p> <p>18 through any particular process, trigger the</p> <p>19 consideration of rule 35, does it?</p> <p>20 A. No. There's no automatic triggering of rule 35, and</p> <p>21 I think that's very clear from the lack of rule 35(1)</p> <p>22 and (2) reports.</p> <p>23 Q. Is that also a significant concern in relation to the</p> <p>24 management of those with self-harm and suicidal intent?</p> <p>25 A. Absolutely. I mean, the absence of rule 35(2) reports</p> <p style="text-align: center;">Page 12</p>

<p>1 means that suicidal intent was never communicated to the</p> <p>2 detaining authority in a way that triggered a review of</p> <p>3 the suitability of that person for detention, so that</p> <p>4 safeguard is entirely absent.</p> <p>5 Q. That's a significant concern, clearly. It seems still</p> <p>6 currently to be the case; is that right? Is that your</p> <p>7 experience?</p> <p>8 A. That's absolutely right. I haven't seen any rule 35(2)</p> <p>9 reports since the period of the inquiry.</p> <p>10 Q. You also say in relation to D1527's case at</p> <p>11 paragraph 160 of your statement that it demonstrates the</p> <p>12 use of segregation as an indirect and inappropriate</p> <p>13 means of managing his distress, symptoms of mental</p> <p>14 health problems and self-harm. Is that right?</p> <p>15 A. Yeah, that's absolutely right. Segregation is an</p> <p>16 example of what the security staff have recourse to in</p> <p>17 the absence of mental health training and in the absence</p> <p>18 of an understanding of an appropriate clinical -- they</p> <p>19 are not clinical staff, and in the absence of an</p> <p>20 appropriate clinical response to people at risk of</p> <p>21 self-harm who are distressed or who are difficult to</p> <p>22 manage, people are moved to segregation. So that's very</p> <p>23 concerning for us. That's particularly concerning</p> <p>24 because segregation and isolation are factors that</p> <p>25 actually exacerbate mental health problems, cause</p> <p style="text-align: center;">Page 13</p>	<p>1 A. Yes.</p> <p>2 Q. And, indeed, a rule 35(2)?</p> <p>3 A. 35(2), yes.</p> <p>4 Q. You also say that D1527's case illustrates the use of</p> <p>5 force and restraint on vulnerable detainees and used as</p> <p>6 a potentially harmful and inappropriate tool to manage</p> <p>7 mental health problems and expressions of distress. At</p> <p>8 paragraph 142 of your statement, you discuss the</p> <p>9 incident on 25 April with Yan Paschali that we are all</p> <p>10 very familiar with. You say particularly that the entry</p> <p>11 in the medical records omits all reference to the</p> <p>12 assault or injuries which should have been documented by</p> <p>13 the medical team. Why is it important to accurately</p> <p>14 record a use of force in the medical records, in your</p> <p>15 view?</p> <p>16 A. It is the duty of any healthcare professional. It is</p> <p>17 very clear in the Nursing & Midwifery Council Guidelines</p> <p>18 as in the General Medical Council Guidelines that, as</p> <p>19 professionals, we have to document what has happened,</p> <p>20 what we have done and what our patients have told us,</p> <p>21 and this was clearly, however else it is looked at,</p> <p>22 a very significant event which the nurse was party to.</p> <p>23 So she absolutely had to write down a record for</p> <p>24 posterity of what had happened and her involvement and</p> <p>25 the impact that she observed on her patient. In this</p> <p style="text-align: center;">Page 15</p>
<p>1 deterioration in many mental health conditions, and are</p> <p>2 associated with increased thoughts of self-harm and</p> <p>3 thoughts of suicide, related to the environment and</p> <p>4 segregation and related to social isolation, and so what</p> <p>5 looks like a response to manage the behaviour actually</p> <p>6 exacerbates the behaviour and the symptoms and,</p> <p>7 therefore, that can lead to a cycle in which the</p> <p>8 person's distress becomes worse and the response becomes</p> <p>9 stronger, whereas, actually, what is needed is</p> <p>10 a de-escalation and a therapeutic intervention.</p> <p>11 Q. In your view, healthcare staff should have been raising</p> <p>12 contraindications, reasons not to use segregation in</p> <p>13 D1527's case; is that right? Who should have been</p> <p>14 raising those particular concerns?</p> <p>15 A. So the person in D1527 was seen by mental health nurses,</p> <p>16 by nurses and by the GPs, and all of them had the</p> <p>17 ability to raise concerns. Only the GP was able to do</p> <p>18 a rule 35(1) report to report the person as at risk and</p> <p>19 as deteriorating in detention. So it was important for</p> <p>20 the other professionals to raise their concerns to the</p> <p>21 GP and for the GP to then escalate those concerns and</p> <p>22 communicate as a safeguarding mechanism to prevent</p> <p>23 further harm.</p> <p>24 Q. So, in your view, a rule 35(1) report should have been</p> <p>25 completed in his case?</p> <p style="text-align: center;">Page 14</p>	<p>1 case, clearly, there was a serious safeguarding concern</p> <p>2 to be reported, so that would just add to it. But, in</p> <p>3 any event, it should have been documented.</p> <p>4 Q. He didn't appear to receive an examination of his mental</p> <p>5 state after the incident. Is that right?</p> <p>6 A. No, that's absolutely right, and I think that perhaps</p> <p>7 follows from the failure to document and communicate it</p> <p>8 within the team. The implication of it not being in the</p> <p>9 notes is that people later wouldn't know about it and,</p> <p>10 therefore, care wouldn't be provided.</p> <p>11 Q. Have you looked at the note that was recorded in the</p> <p>12 medical records by Nurse Joanne Buss?</p> <p>13 A. Yes, but I think you'll have to remind me.</p> <p>14 Q. I can certainly do that. It is <CJS001002>, please, at</p> <p>15 page 38. Just scroll down slightly, please. There is</p> <p>16 the entry on 25 April at 18:51 by Staff Nurse</p> <p>17 Joanne Buss:</p> <p>18 "Placed on rule 40 constant supervision as he</p> <p>19 refused to return to E wing. Called to E wing at approx</p> <p>20 1900. Constant watch. Had placed a ligature around his</p> <p>21 neck. Removed by staff. Staff trying to engage with</p> <p>22 him. RMN Dallah tried to engage with him with minimal</p> <p>23 effect. Put mobile phone battery in his mouth which he</p> <p>24 later removed battery removed from his room. Went to</p> <p>25 toilet and attempted to self-strangulate. Angry and not</p> <p style="text-align: center;">Page 16</p>

<p>1 engaging with staff. Hands removed from his neck by 2 staff. Salivating ++. Unable to take any 3 observations. Visual obs resps 16." 4 Respiratory rate 16; is that right? 5 A. Yes. 6 Q. "Slight redness noted on his neck. 20:00 got up and 7 walked around room. Taken a small drink. Restless. 8 Constant watch continues. Not engaging with staff. 9 Plan: please review later this evening." 10 Does that adequately record what we have all now 11 seen several times in the footage? 12 A. What we have seen in the footage is a clearly very 13 dangerous act by a member of the security staff putting 14 his hands on the person's throat, and so I don't think 15 that is recorded at all or any intervention or response 16 to it. So I don't think this reflects what I have seen 17 in the footage at all. 18 Q. Even leaving aside the particular, as it has been 19 called, "choke hold" applied by Yan Paschali, does "Had 20 placed a ligature around his neck. Removed by staff" 21 adequately record the use of force upon D1527, even 22 leaving aside the choke hold? 23 A. No, I don't think so, no. I think there's much more 24 explanation of what happened. I can appreciate the 25 nursing notes would be brief, but this is a very serious</p> <p style="text-align: center;">Page 17</p>	<p>1 the underlying causes of food and fluid refusal are not 2 routinely explored. Is that your experience in relation 3 to detainees who are refusing food and fluids? 4 A. Yes, absolutely. Quite often, the only documentation is 5 just refusing food or refusing fluids, but the reasons 6 why are many. So we often see people who are in 7 detention who have lost their appetite because of their 8 mental health symptoms or we see people who have 9 paranoid beliefs about the detention environment 10 refusing food for that reason. It's correct that 11 sometimes people are also protesting their treatment and 12 the one thing they have recourse to is to refuse food. 13 But I don't think we can assume -- especially as 14 clinicians, it's really important not to assume that the 15 reason is a protest or a disruptive behaviour without 16 exploring -- 17 Q. Did that seem to be -- 18 A. Absolutely. 19 Q. That seemed to be the assumption, that it was simply 20 a protest, a conscious choice? 21 A. Yes. 22 Q. And not as a result of underlying mental ill-health or 23 distress at being in detention? 24 A. No, absolutely. I think that type of assumption we see 25 often and we continue to see.</p> <p style="text-align: center;">Page 19</p>
<p>1 incident that you would expect somebody to record in 2 detail. 3 Q. Does "angry and not engaging with staff" really cover 4 accurately the presentation D1527 had in really quite 5 severe mental health -- a mental health episode and 6 distress? 7 A. I think this is an example of the sort of way that 8 mental health symptoms can be reinterpreted as 9 behavioural symptoms. We know that this is a person 10 with post-traumatic stress disorder who would likely be 11 very frightened in this type of threatening situation 12 that he would inevitably perceive as threatening, and so 13 this use of this type of terminology "angry and not 14 engaging", it really misses the more clinical 15 observations that I would expect clinical staff to be 16 able to make about levels of anxiety and distress and 17 mental health symptoms. 18 Q. Yes. 19 A. So I think "angry and not engaging" doesn't really 20 capture the clinical presentation. 21 Q. It is not accurate? 22 A. No. 23 Q. I'd like to move on then, please, to D13. You say in 24 relation to this case that, in relation to food and 25 fluid refusal, a fundamental part of the problem is that</p> <p style="text-align: center;">Page 18</p>	<p>1 Q. Food and fluid refusal didn't seem routinely to lead to 2 consideration of rule 35(1) or, indeed, rule 35(2) 3 reports. Was that your experience? 4 A. Yes, and that clearly follows from a failure to look for 5 and understand the root causes of the food and fluid 6 refusal. 7 Q. In your view, had it been appropriately considered, 8 should there have been likely more rule 35(1) and, 9 indeed, rule 35(2) reports in relation to some detainees 10 who were refusing food and fluids? 11 A. Yes, that's right. Because, for example, in the cases 12 I mentioned where somebody has lost their appetite 13 through their mental health or where somebody has 14 developed paranoid beliefs, often that is a consequence 15 of the mental health deterioration in the detained 16 environment and clearly that fits into rule 35(1), 17 particularly now if the person is not eating or 18 drinking, their physical health is at risk as well. So 19 it would be really important to communicate. 20 Q. You have also said that it's necessary to consider an 21 assessment of mental capacity when someone refuses food 22 and fluids. Was that routinely happening, in your 23 experience? 24 A. No, I don't think that was routinely happening, no. 25 Q. Should it have been?</p> <p style="text-align: center;">Page 20</p>

<p>1 A. Yes. So especially at the point where somebody's health 2 or physical health is impacted by refusal of food or 3 fluids, a mental capacity adjustment is essential. It 4 is part of Department of Health guidance for how to 5 manage food and fluids – people who are refusing food 6 or fluids so it is something I would expect healthcare 7 staff to be aware of, but we see that that very often 8 does not happen.</p> <p>9 Q. You say often detainees were put on an ACDT who were 10 refusing food and fluids. That was the case, indeed, 11 with D1527. Was that an appropriate response or 12 adequate management of what perhaps were underlying 13 reasons for food and fluid refusal?</p> <p>14 A. No, as I have said about ACDT, that's not a clinical 15 response, so that's just a behavioural management 16 response from the security staff. So that doesn't 17 necessarily involve healthcare and it doesn't trigger 18 any of the safeguards like rule 35 that were so 19 important in this case. It definitely doesn't trigger 20 a mental capacity assessment. So it doesn't lead to any 21 clinical protection of that person.</p> <p>22 Q. You say that ACDT has become, or is, indeed, 23 disconnected from the Adults at Risk framework. Should 24 the Adults at Risk framework come into play in relation 25 to food and fluid refusal?</p> <p style="text-align: center;">Page 21</p>	<p>1 effect on his mental vulnerabilities and risk to 2 himself. Should a rule 35(1) report have been 3 considered in his case?</p> <p>4 A. Yes, absolutely. So that goes both ways. His mental 5 health feeds into why he might be refusing food and 6 fluid. And food and fluid refusal, if it is prolonged 7 or repeated, may also have a detrimental effect on his 8 mental health. So it needed to be considered as a whole 9 picture.</p> <p>10 Q. And indeed, there should have been consideration of 11 a rule 35(2) report given overlapping suicidal ideation?</p> <p>12 A. Yes, and as he was required to be on ACDT for a long 13 time, it shows he was considered to present an active 14 risk, but that safeguard was just not implemented.</p> <p>15 Q. Looking briefly at the assessment of mental capacity, 16 you look at the case of D1275 at paragraphs 81 to 96 of 17 your statement, and you say, in relation to -- sorry, 18 paragraph 93. In relation to the assessment of mental 19 capacity of detainees, the approach in D1275's case 20 exposes the detriment to a vulnerable detainee caused by 21 the absence of a structured process by which concerns 22 about a detainee's mental capacity are raised, 23 investigated by whom, or guidance on what action should 24 be considered thereafter. There wasn't a structured 25 process. Was there any process for identifying issues</p> <p style="text-align: center;">Page 23</p>
<p>1 A. Yes. If the person is properly assessed and their 2 mental and physical health are assessed, and then, if 3 they're found to be, as in the cases I've mentioned, 4 refusing food and fluid as a result of mental health 5 issues or as a result of deterioration in detention, 6 then that absolutely should trigger the Adults at Risk 7 policy.</p> <p>8 Q. So if we look at D13 then. It is at paragraph 79(b) at 9 page 28 of your statement. This is someone who 10 intermittently stopped eating for various short periods 11 throughout his detention at Brook House. There was 12 a delay in identifying several episodes of food refusal 13 and triggering the food and fluid refusal monitoring 14 process, with observations belatedly imposed only 15 several days after D13 had stopped eating. Just dealing 16 with those observations, they tended to just be physical 17 observations; was that your experience?</p> <p>18 A. Yes, absolutely. So the person might get their blood 19 pressure recorded if they agreed, but there is very 20 rarely an exploration of their mental health.</p> <p>21 Q. D13 was open to the mental health team throughout and 22 subject to an ACDT for an overlapping period on account 23 of his suicidal ideation. But you say there was no 24 substantive assessment of the motivation for his food 25 refusal or the potential interplay with an exacerbating</p> <p style="text-align: center;">Page 22</p>	<p>1 about mental capacity?</p> <p>2 A. No, this is a really difficult case of a person who 3 became very mentally unwell and lost mental capacity, 4 but I think the failures in this case are illustrative 5 of failures we are seeing in the bigger picture. In 6 this case, perhaps he was identified as somebody about 7 whom there should be concerns because he was repeatedly 8 booked in to see mental health staff. So this is 9 a person who actually missed 13 appointments with the 10 mental health team. On three occasions, he was 11 discharged from the mental health caseload and the 12 missed appointments, unfortunately, are summarised in 13 the medical records as a number of hours used up or 14 wasted, if you like, rather than identifying that loss 15 of appointments as a concern in itself: why did he keep 16 being booked in for mental health appointments and not 17 turning up should be an indicator that there's something 18 going on, requiring more assessment. And in this case, 19 those concerns are actually flagged up by the security 20 staff. So security staff have asked for appointments 21 with healthcare. At one point, security staff have 22 raised the question of whether he has capacity to attend 23 those appointments.</p> <p>24 Q. Yes. But none of that was followed up?</p> <p>25 A. But none of it was followed up. On one occasion,</p> <p style="text-align: center;">Page 24</p>

<p>1 a nurse attended the wing but didn't manage to speak to</p> <p>2 him and then nothing else happened afterwards. So there</p> <p>3 is enough -- looking at the notes now, there is enough</p> <p>4 information to see that there are concerns, but because</p> <p>5 there was no attempt to engage him, there was no message</p> <p>6 sent to him, there was no further telephone call to him,</p> <p>7 there was no further trip to the wing to try to find</p> <p>8 him, but because he wasn't engaged, he wasn't properly</p> <p>9 assessed, and his mental capacity concerns were not</p> <p>10 identified. In this case, that leads, as in other</p> <p>11 cases, to just a documented deterioration in his mental</p> <p>12 health. We don't -- of course we don't know what would</p> <p>13 have happened if his mental capacity had been identified</p> <p>14 earlier, but we know that he was in detention for over</p> <p>15 a year without that being identified, and sadly, after</p> <p>16 release, he was so unwell that quite soon after release</p> <p>17 he was admitted under the Mental Health Act to</p> <p>18 a psychiatric hospital under a section. So he was</p> <p>19 a person whose health was really harmed by that process.</p> <p>20 Q. He was assessed to have bipolar affective disorder or</p> <p>21 a psychotic illness and that he lacked capacity --</p> <p>22 A. Yes.</p> <p>23 Q. -- but only after he was released from detention after</p> <p>24 a considerable period of time, as you say?</p> <p>25 A. Yes.</p> <p style="text-align: right;">Page 25</p>	<p>1 rule 35 reports not being written, or indeed considered,</p> <p>2 at the rule 34 GP assessment that's required within</p> <p>3 24 hours of arrival at an IRC. Do you remember that?</p> <p>4 A. Yes.</p> <p>5 Q. But the practice being that a second assessment</p> <p>6 appointment was booked if something was flagged</p> <p>7 initially through screening or in that appointment,</p> <p>8 sometimes booked after, indeed, a considerable delay.</p> <p>9 Do you have any comment upon that practice that appears</p> <p>10 to still be ongoing?</p> <p>11 A. Yes. I think the practice is still ongoing. What we</p> <p>12 see in the initial GP appointment doesn't seem to fulfil</p> <p>13 a rule 40 appointment. What we see tends to be an</p> <p>14 assessment of immediate health needs in detention. So</p> <p>15 usually limited to prescription of medication for</p> <p>16 long-term conditions. It's not a systematic assessment</p> <p>17 of the person's risks in detention. So it doesn't</p> <p>18 include a detailed assessment of their mental health, of</p> <p>19 their physical health, other than those perhaps</p> <p>20 medication needs that have been flagged up. And it</p> <p>21 doesn't identify people that might, for example, be</p> <p>22 survivors of torture. So it doesn't feed in -- it can't</p> <p>23 feed into the rule 35 process automatically because</p> <p>24 there isn't enough detailed assessment. We heard from</p> <p>25 the doctor that even where those risks were flagged up,</p> <p style="text-align: right;">Page 27</p>
<p>1 Q. There was no rule 35(1) or any type of rule 35 report in</p> <p>2 his case?</p> <p>3 A. No, exactly. And that's particularly important in this</p> <p>4 case because, if the detention centre staff couldn't</p> <p>5 assess him, they couldn't be assured of his safety and</p> <p>6 they should have communicated his risk if he couldn't be</p> <p>7 managed -- you know, in detention, there is no choice</p> <p>8 about which healthcare team to see. In the community,</p> <p>9 there are a choice of practices, other people the person</p> <p>10 might see, advocacy or support structures the person</p> <p>11 would normally use. But he didn't have that choice.</p> <p>12 There was only the healthcare team there. So if they</p> <p>13 were not able to assess him, they should have</p> <p>14 communicated that they couldn't manage him to the</p> <p>15 Home Office. But, actually, I think what this case</p> <p>16 highlights is a failure to follow through on that</p> <p>17 assessment.</p> <p>18 Q. He simply slipped through the net?</p> <p>19 A. Yes.</p> <p>20 Q. In relation to rule 35, I just want to look at some</p> <p>21 aspects of the rule 34 and rule 35 process. You were</p> <p>22 here on Friday to hear the evidence of Dr Oozeerally and</p> <p>23 Dr Chaudhary, I believe?</p> <p>24 A. Most of it, yes.</p> <p>25 Q. Dr Oozeerally gave evidence of a practice in relation to</p> <p style="text-align: right;">Page 26</p>	<p>1 they weren't reported straight away because a further</p> <p>2 appointment was booked later down the line.</p> <p>3 Q. So leading to delays?</p> <p>4 A. Absolutely.</p> <p>5 Q. So the safeguard under rule 34 isn't operating as</p> <p>6 a safeguard in identifying vulnerability at the outset</p> <p>7 of detention; is that your view?</p> <p>8 A. No, it's not, no.</p> <p>9 Q. In relation to D1525, you say here -- this is in</p> <p>10 relation to rule 35 -- the doctor noted repeated and</p> <p>11 sustained beating by other villagers on account of his</p> <p>12 sexuality which the police did nothing to stop. The</p> <p>13 doctor documented various prominent scars and noted</p> <p>14 flashbacks and anxieties but concluded that the</p> <p>15 incidents of ill-treatment were more of an Adult at</p> <p>16 Risk -- more an issue of an Adult at Risk. You say it</p> <p>17 is concerning that the risk to D1525 of being in</p> <p>18 detention was not further explored. In your view, was</p> <p>19 there an adequate understanding amongst healthcare</p> <p>20 staff, including GPs, concerning the definition of</p> <p>21 torture and the purpose of rule 35(3) as a safeguard?</p> <p>22 A. So to take those two points separately, in terms of</p> <p>23 the definition of torture, as my colleague</p> <p>24 Theresa Schleicher has explained in her witness</p> <p>25 statement, there was a potted history with the</p> <p style="text-align: right;">Page 28</p>

7 (Pages 25 to 28)

<p>1 Home Office where the definition had been changed. It</p> <p>2 is not clear in this period in 2017 how clear the</p> <p>3 doctors were about what the definition was. In this</p> <p>4 case, the rule 35 report includes the old definition,</p> <p>5 which includes that the torture route was authorised by</p> <p>6 the state. So you can see that that's fed into the</p> <p>7 doctor's conclusion there and to say "more of an issue</p> <p>8 of Adult at Risk", but the doctor has missed that the</p> <p>9 clinical point -- actually, his assessment doesn't have</p> <p>10 to be a legal assessment. He's not being asked to</p> <p>11 decide whether or not the person should be a survivor of</p> <p>12 torture. He's being asked to document the psychological</p> <p>13 and physical consequences and the impact of detention on</p> <p>14 that person. And so I think whether or not the person</p> <p>15 was a survivor of torture has perhaps distracted the</p> <p>16 doctor from documenting what he should have focused on,</p> <p>17 which was the risk of harm to that person in detention.</p> <p>18 Q. Being an Adult at Risk doesn't preclude a rule 35(3)</p> <p>19 report. Indeed, it's the opposite, isn't it? It should</p> <p>20 prompt consideration of it?</p> <p>21 A. Well, exactly. I mean, it's the Adults at Risk policy,</p> <p>22 so he needed to communicate why that person was an Adult</p> <p>23 at Risk which he clearly thinks they are.</p> <p>24 Q. You refer at paragraph 103 of your statement to research</p> <p>25 and literature in the public domain that someone who has</p> <p style="text-align: center;">Page 29</p>	<p>1 a GP. So in this sector, we are responsible to be aware</p> <p>2 of the latest professional guidelines, by which I would</p> <p>3 include the successive statements by the Royal College</p> <p>4 of Psychiatrists, because they relate to the mental</p> <p>5 health care of people with mental disorders in</p> <p>6 immigration detention, which clearly the healthcare team</p> <p>7 are responsible for, and now there's NICE guidance about</p> <p>8 PTSD, which was in existence from 2005, they should be</p> <p>9 aware of, and now there's guidance from the Faculty of</p> <p>10 Forensic and Legal Medicine about care for survivors of</p> <p>11 torture in detention.</p> <p>12 Q. Dr Oozeerally didn't seem to be aware of any of that.</p> <p>13 Is that acceptable in your view?</p> <p>14 A. No, I think it's unacceptable, and I find it surprising</p> <p>15 that, being a senior, experienced GP leading others in</p> <p>16 that sector, that he wouldn't not only know about it,</p> <p>17 but be trying to disseminate that information to his</p> <p>18 colleagues and proactively look for it.</p> <p>19 Q. You heard his evidence about how he applied the</p> <p>20 likelihood of harm assessment in relation to victims of</p> <p>21 torture. Do you think he really had any understanding</p> <p>22 of the safeguards under the rules in relation to the</p> <p>23 type of assessment he was meant to be undertaking?</p> <p>24 A. No, I think that there was a lack of understanding about</p> <p>25 the rules. That fits, really, with our experience. So</p> <p style="text-align: center;">Page 31</p>
<p>1 suffered a past history of torture would be at risk of</p> <p>2 harm in detention. Is that right?</p> <p>3 A. Yes, that's right.</p> <p>4 Q. You say that, in the medical community you work in,</p> <p>5 IRCs, it's well known that that's the case, that simply</p> <p>6 having a past history of torture or trauma involves</p> <p>7 a risk of harm in detention?</p> <p>8 A. Yes. So I don't think it's possible to escape that</p> <p>9 information, really, because it's the kind of unanimous</p> <p>10 professional consensus if you look at research into</p> <p>11 mental health in immigration detention. For example,</p> <p>12 a meta analysis looking at all the recent studies of</p> <p>13 mental health in immigration detention. The</p> <p>14 von Werthern study in 2018 reported that all the adult</p> <p>15 studies showed an association between immigration</p> <p>16 detention and detrimental impact on mental health. So</p> <p>17 it's not that there's kind of conflicting literature to</p> <p>18 find.</p> <p>19 As GPs, of course, this is a specialist field, and</p> <p>20 I understand, of course, not all of us work with asylum</p> <p>21 seeker/refugee populations, but --</p> <p>22 Q. But those who work in IRCs definitely do?</p> <p>23 A. Exactly, and our duties, as a doctor, is to keep</p> <p>24 ourselves abreast of information and guidelines which</p> <p>25 are relevant to our work, not to other types of work as</p> <p style="text-align: center;">Page 30</p>	<p>1 rule 35(3) reports tend to be done, albeit with the</p> <p>2 problems that I have described in my witness statement</p> <p>3 with them, but we know from Dr Oozeerally's evidence and</p> <p>4 from the other evidence that rule 35(1) was very rarely</p> <p>5 done and rule 35(2) was never done, and so, you know, we</p> <p>6 have heard from them that they were just not doing --</p> <p>7 not participating in that safeguard, which is clearly</p> <p>8 a policy that applies to their work and clearly a very</p> <p>9 important part of safeguarding because that's the only</p> <p>10 mechanism by which the detention of people identified as</p> <p>11 Adults at Risk will be reviewed by the Home Office.</p> <p>12 Q. In relation to a failure to address mental health</p> <p>13 aspects in rule 35 reports and, indeed, a failure to</p> <p>14 assess the impact of detention, you looked at the case</p> <p>15 of D2442 at paragraph 110 of your statement. This</p> <p>16 detainee gave an account of torture under the mental</p> <p>17 health section of the report. It was noted that he had</p> <p>18 been started on some medication due to low mood and</p> <p>19 thoughts of ending his life. He was also noted to be</p> <p>20 under the care of the mental health team. He had tried</p> <p>21 to hang himself two days before the rule 35 assessment.</p> <p>22 Yet, despite that, and despite what were clear and</p> <p>23 obvious reported symptoms, indicators of risk, it</p> <p>24 appears the opinion of the doctor's colleague that</p> <p>25 medication was required, the doctor concluded there was</p> <p style="text-align: center;">Page 32</p>

<p>1 no evidence of severe mental health issues and, 2 therefore, didn't go on to consider the impact of 3 detention. 4 In your view, is the conclusion "no evidence of 5 severe mental health issues" justified in this 6 particular case? 7 A. No, so this is a typical example where a phrase like "no 8 evidence of severe mental health issues" is put in 9 a context where it's then to be interpreted by 10 a non-medical reader and allows clearly for the 11 interpretation that there was no risk of harm to that 12 person in detention. In fact, this person has made 13 a very recent suicide attempt, is under care of 14 the mental health team and is on medication. So there 15 definitely are mental health issues. 16 Q. There are mental health issues. 17 A. But that's not communicated. I think one of the reasons 18 for that may be a use of severe mental health issues to 19 refer to psychotic mental illness, and, clinically, 20 perhaps, that's a category that's recognisable and it 21 makes sense, but it doesn't mean -- it doesn't relate to 22 the severity. So somebody could have PTSD or 23 depression, but not have that category of mental health 24 issue, so they are not psychotic, but they still have 25 severe mental health issues and are at risk in</p> <p style="text-align: right;">Page 33</p>	<p>1 think there is any sort of further safety net where that 2 decision is fed back to the doctor and the doctor should 3 then review -- see the person again. If they were at 4 risk of harm in detention and they are still in 5 detention, they should be specifically reviewed to see 6 what's happened to them since. 7 Q. There seems to be no system at all for ongoing review? 8 A. There is no system for that. 9 Q. A significant number of rule 35(3) reports from the 10 period, but indeed likely ongoing, continue to fail to 11 identify the impact of detention upon a detainee at the 12 point where the rule 35(3) report is done? 13 A. Yes, that's usually not considered, yes. 14 Q. In relation to the use of Part C forms, there was some 15 evidence given by both Dr Oozeerally and Dr Chaudhary on 16 Friday that they used the Part C form to inform the 17 Home Office of a deterioration in a detainee's health 18 instead of, or potentially in addition to, rule 35, 19 which Dr O referred to as a weighty document. In other 20 words, that a rule 35 report was a weighty document. Do 21 you agree that it is a weighty document? 22 A. I know -- I mean, as a GP, I can relate to being busy 23 and not wanting to duplicate efforts, but I don't think 24 in this case it's very difficult. They can have 25 a technology to copy and paste their findings into the</p> <p style="text-align: right;">Page 35</p>
<p>1 detention. I think that's the case in this case. But 2 the communication is unclear and the risk is not 3 communicated and so that safeguard, again, fails. 4 Q. Yes. Again, Dr Oozeerally confirmed in his live 5 evidence, as indeed did Dr Chaudhary, that they are 6 still not completing reports under rule 35(2), and 7 indeed Sandra Calver confirmed and, indeed, very few 8 under 35(1). That still remains a significant concern, 9 doesn't it? 10 A. Absolutely. I'm as concerned now as I would have been 11 then that these safeguards just don't operate despite an 12 ongoing, very high prevalence of these types of mental 13 health issues in people in immigration detention. 14 Q. The concern in relation to rule 35(3) reports is that 15 frequently, as in D442's case, where there's a failure 16 to consider the impact of detention on him, even though 17 the form directs it, there is then a reliance by the 18 Home Office upon that lack of consideration in 19 maintaining detention, in cases where potentially there 20 shouldn't have been; is that right? 21 A. Yes, absolutely. So the rule 35(3), as we see 22 repeatedly, the doctor is quoted and cited in decisions 23 to maintain detention. It will say, "The doctor has not 24 identified any harm to your health in detention", so we 25 know how important that is. We don't know, and I don't</p> <p style="text-align: right;">Page 34</p>	<p>1 same report and I'm sure if they understand the 2 importance of this safeguard, it would be clear that 3 that's what needs to happen. 4 I note the same people have not raised concerns that 5 they didn't have time to safely do their work, and 6 I think that's the pathway. If you don't have time to 7 follow safeguarding procedure, then you surely need to 8 raise concerns that you don't have time to do your work. 9 Q. I'm summarising, but the evidence that Dr Oozeerally 10 gave for the reasons for using Part C instead of rule 35 11 reports was that it was a more dynamic way of informing 12 the Home Office of concerns. They would get a response 13 quicker. And, in his experience, the receipt of 14 a Part C would lead the Home Office to review detention 15 and, indeed, release detainees, even though there's no 16 statutory requirement for the Home Office to have done 17 so. Is that your experience of the use of Part C? 18 A. No, it's not, no, because we see cases where there are 19 Part Cs in the notes and detention has not been reviewed 20 and the person stays in detention, but we also see cases 21 where there is no Part C and no concerns raised. But, 22 in any case, the important point is that, what's 23 actually a safeguard is something that requires 24 a response. So this is the same in all of our 25 safeguarding training for safeguarding adults and</p> <p style="text-align: right;">Page 36</p>

<p>1 children: there needs to be a process which triggers</p> <p>2 a response and can then be reviewed. Part C doesn't</p> <p>3 require a response, it doesn't require a review of</p> <p>4 the detention by the Home Office. So it's not</p> <p>5 a safeguard. It might be a communication in the best</p> <p>6 case scenario that they are saying happened sometimes,</p> <p>7 but it doesn't trigger a review of detention, so it is</p> <p>8 not a safeguard.</p> <p>9 Q. In relation to Part Cs, they are also more general than</p> <p>10 just a concern about a detainee's health or risk, aren't</p> <p>11 they? They can be about a number of other different</p> <p>12 things. So it is not focused upon vulnerability in the</p> <p>13 same way that rule 35 is?</p> <p>14 A. No, that's right. It's not part of the Adults at Risk</p> <p>15 policy as a safeguard to flag up those safeguarding</p> <p>16 vulnerabilities. So it's not a safeguard, that's right.</p> <p>17 Q. In relation to D801, then, he had four Part Cs completed</p> <p>18 in relation to him and sent to the Home Office. He had</p> <p>19 arrived in Brook House on 1 March 2017. His screening</p> <p>20 by a nurse indicated a diagnosis of PTSD and a history</p> <p>21 of torture. An ACDT was opened due to an increased risk</p> <p>22 of self-harm, but no rule 35(3) report was done at that</p> <p>23 time and, indeed, no rule 35 assessment appointment was</p> <p>24 booked for him; is that right?</p> <p>25 A. No, thank you, and thank you for summarising. I think</p> <p style="text-align: center;">Page 37</p>	<p>1 a different type of treatment who was at risk of harm in</p> <p>2 detention because of the symptoms you read there that</p> <p>3 are characteristic symptoms of trauma-related mental</p> <p>4 disorder.</p> <p>5 Q. He was also the subject of a Part C completed by</p> <p>6 Sandra Calver that I asked her about when she gave her</p> <p>7 evidence, and he was noted on that Part C to be an Adult</p> <p>8 at Risk at level either 2 or 3. At that stage, again,</p> <p>9 no rule 35 report completed. Again, there should have</p> <p>10 been, shouldn't there?</p> <p>11 A. Yes, yes.</p> <p>12 Q. And he was maintained in detention after the Part C on</p> <p>13 13 March. On 19 March, it is noted in the medical</p> <p>14 records that the previous day he had applied a ligature,</p> <p>15 so a serious episode of self-harm, potentially a suicide</p> <p>16 attempt. Would you agree?</p> <p>17 A. Yes, absolutely, yes.</p> <p>18 Q. And, again, a Part C was completed on 19 March to notify</p> <p>19 the Home Office of the ligature. Again, he was</p> <p>20 maintained in detention after that Part C was sent to</p> <p>21 the Home Office. Again, at that stage, a rule 35(1)</p> <p>22 and/or a rule 35(2) report should have been completed,</p> <p>23 shouldn't it?</p> <p>24 A. Absolutely. So the rule 35(1) should have been done</p> <p>25 already and certainly could have been done again.</p> <p style="text-align: center;">Page 39</p>
<p>1 that's a clear example of repeated Part Cs not</p> <p>2 triggering a review of detention.</p> <p>3 Q. If we look at just the chronology of the Part Cs and</p> <p>4 what was happening when each one was raised, he didn't</p> <p>5 attend his routine rule 34 assessment that was booked</p> <p>6 for him on 1 March. That was with a GP. That was the</p> <p>7 day he arrived. But he did see Dr Belda, who was</p> <p>8 a psychiatrist, on 2 March, who noted:</p> <p>9 "He is experiencing flashbacks, overwhelming anxiety</p> <p>10 and high emotional arousal, insomnia, nightmares and</p> <p>11 severely low startle reaction."</p> <p>12 He also noted he was very distressed during the</p> <p>13 appointment. A Part C had been completed in relation to</p> <p>14 D801 on 1 March, but he was maintained in detention</p> <p>15 after that. The plan Dr Belda had on 2 March was to</p> <p>16 transfer him to hospital under section 48 of the Mental</p> <p>17 Health Act. Does that indicate that Dr Belda thought he</p> <p>18 was very unwell, he needed inpatient psychiatric</p> <p>19 treatment?</p> <p>20 A. Yes, that's right.</p> <p>21 Q. At that stage, at 2 March, with that assessment, there</p> <p>22 should have been a rule 35(3) and, indeed, a rule 35(1)</p> <p>23 report, shouldn't there?</p> <p>24 A. Yes, absolutely. They clearly identified a person who</p> <p>25 couldn't be managed in detention who required</p> <p style="text-align: center;">Page 38</p>	<p>1 Rule 35(2), because suicidal intent has been</p> <p>2 demonstrated by a very serious suicide attempt,</p> <p>3 unfortunately.</p> <p>4 Q. And he, again, remained in detention. A note on</p> <p>5 31 March in his medical records prompting the last</p> <p>6 Part C in relation to him recorded by Dallah Dowd that</p> <p>7 he wasn't fit to be in Brook House, he was unfit for</p> <p>8 detention, he should be released on health grounds, that</p> <p>9 he needed specific trauma therapy which cannot be</p> <p>10 provided at Brook House, and there had been no change in</p> <p>11 his clinical presentation to previously. This was in</p> <p>12 circumstances where his section 48 transfer had been</p> <p>13 cancelled, but not that he had improved; is that right?</p> <p>14 A. No, that's right. In this case, my understanding is</p> <p>15 that the person had severe PTSD and that was the need</p> <p>16 for hospital treatment. It's actually illustrative of</p> <p>17 the fact that PTSD is not best managed in a detained or</p> <p>18 secure environment. People with PTSD should be managed,</p> <p>19 have to be managed, in a situation in which they're able</p> <p>20 to feel safe and secure and stable and to engage in</p> <p>21 treatment with somebody that they can build a trusting</p> <p>22 relationship with. So a secure hospital is not the</p> <p>23 ideal situation for somebody with that condition.</p> <p>24 Certainly an immigration detention is not. The ideal</p> <p>25 context is in the community, which eventually was</p> <p style="text-align: center;">Page 40</p>

<p>1 established in this case.</p> <p>2 Q. To finish it off, he did eventually, on 3 April, some --</p> <p>3 more than a month after he had been received into</p> <p>4 detention, have a rule 35(1) report completed on him by</p> <p>5 Dr Chaudhary, and he was, by the time of the rule 35</p> <p>6 response from the Home Office, released.</p> <p>7 A. Yes.</p> <p>8 Q. So, eventually, the safeguard kicked in, but far too</p> <p>9 late, in your view?</p> <p>10 A. Certainly far too late because harms that could have</p> <p>11 been foreseen on the second day of his detention, that</p> <p>12 he was somebody who had very high risk of deterioration</p> <p>13 in the detained environment because he was identified as</p> <p>14 having PTSD, was kept in detention so that his symptoms</p> <p>15 could be exacerbated, and suffering to the extent of</p> <p>16 causing a suicide attempt and so on, as you have</p> <p>17 explained.</p> <p>18 Q. Rule 35(1) in particular, we have been talking about</p> <p>19 harm being caused in detention, but the rule actually</p> <p>20 only requires that it is likely to be harm -- likely to</p> <p>21 be caused, doesn't it?</p> <p>22 A. Yes, that's exactly right. The fact that a rule 35(1)</p> <p>23 was done in this case when we know there are so few</p> <p>24 shows the type of extreme case that might trigger it in</p> <p>25 a GP, where a psychiatrist has recommended transfer to</p> <p style="text-align: center;">Page 41</p>	<p>1 the healthcare team and specifically of the GPs to</p> <p>2 implement these safeguards.</p> <p>3 Q. That remains the case currently?</p> <p>4 A. It does.</p> <p>5 Q. As we know. Dr Oozeerally, in his live evidence on</p> <p>6 Friday, also placed reliance on the ability of the GPs</p> <p>7 and the mental health team to manage a detainee's health</p> <p>8 in detention as a reason not to do these reports. Do</p> <p>9 you have any comment upon that practice?</p> <p>10 A. What we generally see is the GP's role is quite limited</p> <p>11 to prescribing medication or referring to the mental</p> <p>12 health team. The mental health team management is -- so</p> <p>13 there's mental health nurses in detention with access to</p> <p>14 psychiatrists, but their role is quite limited to</p> <p>15 assessment and some supportive interventions. They are</p> <p>16 not able to provide therapy, psychological therapy, in</p> <p>17 detention because, as I mentioned, in order to do that,</p> <p>18 you need the person to be in a safe environment in which</p> <p>19 they can engage with treatment, and this is really</p> <p>20 clearly explained in the Royal College of Psychiatrists'</p> <p>21 position statement, that the majority of mental</p> <p>22 disorders cannot be managed in detention, and that was</p> <p>23 a clear finding repeated in the Shaw Review in 2016, so</p> <p>24 known before the period of the inquiry. People couldn't</p> <p>25 get good care in detention for their mental health. So</p> <p style="text-align: center;">Page 43</p>
<p>1 hospital, but that really illustrates how people are</p> <p>2 left to deteriorate until such an intervention is</p> <p>3 required rather than flagged up, which doesn't fit with</p> <p>4 the idea of an Adults at Risk policy that should try to</p> <p>5 identify risk rather than actual harm, as in this case.</p> <p>6 Q. It is required by the rule, isn't it?</p> <p>7 A. Yes.</p> <p>8 Q. As well. The rule isn't being applied in the way that</p> <p>9 it's supposed to be?</p> <p>10 A. No, exactly, yes.</p> <p>11 Q. Far too high a threshold, as Sandra Calver accepted, is</p> <p>12 being applied in relation to rule 35(1) reports, which</p> <p>13 perhaps is one of the reasons why we see so few of them?</p> <p>14 A. Yes, exactly, because they are done when people have</p> <p>15 been allowed to deteriorate to such an extent instead of</p> <p>16 done to identify risk as per the policy.</p> <p>17 Q. In terms of the reasons for the lack of rule 35(1)</p> <p>18 reports, part of the reason might be a lack of time and</p> <p>19 resources. Would you agree?</p> <p>20 A. As I said, I just don't think that is an acceptable</p> <p>21 reason, because I don't think that's been flagged up as</p> <p>22 a reason. I think there's a failure to recognise the</p> <p>23 importance of the safeguards. There's a failure to</p> <p>24 recognise the risks people are facing in detention. And</p> <p>25 a failure to recognise the responsibilities of</p> <p style="text-align: center;">Page 42</p>	<p>1 the GP management is -- can't be seen as adequate. It</p> <p>2 is not equivalent to what would happen in the community.</p> <p>3 Q. I'd like to move on to another case study, please,</p> <p>4 D1914. You look at this at paragraph 80(c) on page 30</p> <p>5 of your statement. You comment that the rule 34 process</p> <p>6 didn't seem to have identified adequately his physical</p> <p>7 health issues. We know that he suffered from a serious</p> <p>8 heart condition and had a complex clinical history. He</p> <p>9 was taken to A&E by ambulance whilst he was at</p> <p>10 Brook House on multiple occasions after he complained of</p> <p>11 chest pains and palpitations and following a blood test</p> <p>12 result indicating a possible blood clot. Is that right?</p> <p>13 A. Yes, that's all right.</p> <p>14 Q. Does that sound to you as someone who has a stable</p> <p>15 cardiac condition?</p> <p>16 A. No, well, I reviewed his detention centre medical</p> <p>17 records, and which included some letters from his</p> <p>18 cardiologist, and they show that he'd had a coronary</p> <p>19 artery bypass graft some time before he was detained</p> <p>20 and, although an interval had passed of some months, he</p> <p>21 was waiting for a further procedure, which was</p> <p>22 a catheter procedure, so an intervention through a blood</p> <p>23 vessel, to treat an abnormal heart rhythm. So when he</p> <p>24 said he was having palpitations, he had episodes of an</p> <p>25 abnormal heart rhythm for which he was awaiting</p> <p style="text-align: center;">Page 44</p>

<p>1 treatment. So we know he is a person with serious</p> <p>2 cardiac disease because he's required a coronary artery</p> <p>3 bypass graft and we know his condition has not been</p> <p>4 stabilised because he's waiting for a further procedure.</p> <p>5 All of that information was available in the medical</p> <p>6 records and it was known early on in his detention. So</p> <p>7 he could have been identified early on as somebody who</p> <p>8 had a cardiac condition which would have contraindicated</p> <p>9 specifically the use of restraint, which you might come</p> <p>10 to, and also meant he was unfit to fly.</p> <p>11 Q. He didn't receive a rule 35(1) report until almost four</p> <p>12 months into his detention. In your view, should he have</p> <p>13 received one much earlier than that?</p> <p>14 A. Yes. I think those medical vulnerabilities should have</p> <p>15 been flagged up very early on. He also had mental</p> <p>16 health issues and episodes of serious self-harm and</p> <p>17 suicide attempts in detention. So there were multiple</p> <p>18 indicators to flag up his risk in detention, which</p> <p>19 should have been done much earlier.</p> <p>20 Q. Let's come to the use of force then. We know that D1914</p> <p>21 was subject to a planned use of force in relation to an</p> <p>22 order to effect his removal to E wing on 27 May 2017 in</p> <p>23 advance of his charter flight. He had a serious heart</p> <p>24 condition, as we have just discussed, and he also, as</p> <p>25 you said, had a history of serious self-harm. He'd been</p> <p style="text-align: center;">Page 45</p>	<p>1 clearly steps beyond the boundaries that that doctor</p> <p>2 should have. This is clearly flagged up in guidance for</p> <p>3 doctors working in this area, so that the BMA report for</p> <p>4 doctors working in immigration detention explains about</p> <p>5 dual loyalties and how doctors can get drawn into</p> <p>6 custodial systems and, as GPs in that environment, they</p> <p>7 need to be constantly on their guard for that and really</p> <p>8 watch their language so that it's not, as in this case,</p> <p>9 used in another context to justify a use of force.</p> <p>10 Q. Yes, as it clearly appears to have here. Dr Oozeerally</p> <p>11 also gave evidence that, in writing these letters in</p> <p>12 these sort of terms, he wouldn't always assess the</p> <p>13 patient in person in order to write such a letter. Was</p> <p>14 that appropriate, in your view?</p> <p>15 A. Well, I think, in this case, there was enough</p> <p>16 information on the background information and the</p> <p>17 letters from the cardiologist to say that he was not fit</p> <p>18 to fly and to raise concerns about his restraint. But,</p> <p>19 clearly, for most people, they would need an assessment</p> <p>20 in person because it might not be that crystal clear, as</p> <p>21 I think it was in this case. There is also an issue</p> <p>22 about consent. So we are in a situation where a doctor</p> <p>23 is now going to share information with the detaining</p> <p>24 authority without having had a discussion with his</p> <p>25 patient about what's going to be shared and why and</p> <p style="text-align: center;">Page 47</p>
<p>1 on three ACDTs.</p> <p>2 Dr Oozeerally, as we heard on Friday, had written</p> <p>3 a letter to the Home Office that he was fit to fly and</p> <p>4 fit for detention. Was it appropriate, in your view,</p> <p>5 for GPs to be writing letters to the Home Office in such</p> <p>6 terms?</p> <p>7 A. No, I think there's multiple issues with that. The GP's</p> <p>8 role in use of force is very strictly limited to</p> <p>9 a protective role. So they have no part in authorising</p> <p>10 or planning the use of force. It is not a therapeutic</p> <p>11 intervention. In this case, it was to remove him from</p> <p>12 the country. So it had nothing to do with his clinical</p> <p>13 care and, therefore, it has nothing to do with the</p> <p>14 doctors. Except that, in this context, they have a very</p> <p>15 specific safeguarding duty before, during and after</p> <p>16 a use of force, and so their role -- I don't think it's</p> <p>17 being too technical. Dr Oozeerally said the language</p> <p>18 amounted to the same thing, but, actually, the language</p> <p>19 is how we separate this role clearly in our</p> <p>20 documentation. So saying there's no medical</p> <p>21 contraindications is the limits of the doctor's</p> <p>22 involvement in a use of force.</p> <p>23 Q. And it is very different from saying that he's happy for</p> <p>24 reasonable force to be used?</p> <p>25 A. Absolutely, because that's an endorsement and that very</p> <p style="text-align: center;">Page 46</p>	<p>1 whether or not there was consent for that information to</p> <p>2 be shared. Of course, that information, as he is the</p> <p>3 patient's GP in this situation, he needed to have the</p> <p>4 patient's consent to share that information.</p> <p>5 Q. And he should have been raising both the physical</p> <p>6 condition and the self-harm as contraindications to the</p> <p>7 use of force prior to the planned use of force, in your</p> <p>8 view?</p> <p>9 A. Yes, absolutely.</p> <p>10 Q. And you remain of that view, even though Dr Oozeerally</p> <p>11 disagreed with you in his live evidence saying his</p> <p>12 condition was stable and neither of those things was</p> <p>13 a reason not to use force in this case?</p> <p>14 A. I do remain of that view. I could see that</p> <p>15 Dr Oozeerally didn't have the medical records in front</p> <p>16 of him, but I have reviewed them before and since</p> <p>17 hearing that evidence, and I remain of that view, yes.</p> <p>18 Q. You say also, in relation to D1914, at paragraph 145,</p> <p>19 that his case also appears to be an example of</p> <p>20 a misconception among staff that non-compliant</p> <p>21 behaviours are indicative of deliberate disobedience</p> <p>22 rather than a manifestation of underlying vulnerability,</p> <p>23 such as self-harm or mental ill-health or distress. Is</p> <p>24 that your view in relation to him?</p> <p>25 A. Yes. So in relation to this person, I think there's</p> <p style="text-align: center;">Page 48</p>

<p>1 a very high risk that that is what was happening. There</p> <p>2 are snapshots, for example, in the nursing notes that</p> <p>3 this particular patient, D1914, was noted by the nurse</p> <p>4 to be very anxious, hyperventilating, tearful. We have</p> <p>5 seen, in the Panorama footage, unfortunately, evidence</p> <p>6 of very severe self-harm and suicide attempts, so</p> <p>7 a significant overdose, blood found in his room, very</p> <p>8 large cuts on his body. We have seen these</p> <p>9 manifestations of distress there and also in some</p> <p>10 snapshots in the medical entries. But the overall view</p> <p>11 is the treatment of him through custodial processes,</p> <p>12 through use of force, through ACDT. These are managing</p> <p>13 as behaviour. So they're management -- how you would</p> <p>14 manage if you didn't think somebody was unwell. There</p> <p>15 is no justification for managing somebody with mental</p> <p>16 health problems in a high degree of distress through</p> <p>17 these restrictive measures. So it is -- so recourse to</p> <p>18 them shows that the environment hasn't allowed this</p> <p>19 person to be treated as a vulnerable person, to be</p> <p>20 treated as a patient.</p> <p>21 Q. Is that an attitude amongst the detention staff and the</p> <p>22 healthcare staff, including GPs?</p> <p>23 A. Yes, I think there's a very high risk that those things</p> <p>24 go together, because if the GPs don't communicate those</p> <p>25 concerns and don't implement those safeguards, then they</p> <p style="text-align: center;">Page 49</p>	<p>1 a plastic bag over his head, so in the throes of a very</p> <p>2 serious suicide attempt. And still the use of force</p> <p>3 proceeded after that. So at a time when clearly what</p> <p>4 was needed was a compassionate mental health</p> <p>5 intervention.</p> <p>6 Q. Yes, indeed, a shield was placed on his chest while he</p> <p>7 remained lying on the bed and he was then restrained</p> <p>8 prone on the ground, a dangerous position in itself?</p> <p>9 A. Yes.</p> <p>10 Q. His arms were restrained and his head was secured and he</p> <p>11 was escorted to E wing under restraint and in handcuffs.</p> <p>12 He dropped his weight to the ground several times,</p> <p>13 resulting in him being restrained again prone on the</p> <p>14 floor on at least one occasion. That does seem, as you</p> <p>15 say, to be a use of force as a tool to manage and</p> <p>16 respond to an acute episode of self-harm as opposed to</p> <p>17 merely to save life in the immediate moment. Would you</p> <p>18 agree?</p> <p>19 A. Let me be clear. Force was rightly used to remove the</p> <p>20 plastic bag from his head. That was the extent of it.</p> <p>21 After that, he was no longer -- I don't think there is</p> <p>22 a suggestion he was posing risk to anybody else and</p> <p>23 after that had been done, he was no longer an immediate</p> <p>24 risk to himself. But, clearly, he'd just made a very</p> <p>25 serious suicide attempt. We can only assume that he</p> <p style="text-align: center;">Page 51</p>
<p>1 are not feeding into an environment that would listen to</p> <p>2 people and treat them with compassion. They are instead</p> <p>3 participating in an environment that's hostile to those</p> <p>4 people.</p> <p>5 Q. In relation to use of force in a different context, you</p> <p>6 comment about the issue of force being used in response</p> <p>7 to self-harm incidents. We have seen this in a number</p> <p>8 of cases -- D1527's is one, also D687, and one you</p> <p>9 discuss in your statement at paragraph 147(c), D812. In</p> <p>10 your experience, does it seem to have been a widespread</p> <p>11 practice to use force in response to incidents of</p> <p>12 self-harm?</p> <p>13 A. Yes, absolutely. I would say there was very quick</p> <p>14 recourse to use of force rather than to a clinical</p> <p>15 intervention, and that's related to what I said to an</p> <p>16 environment that doesn't perceive these things as</p> <p>17 symptomatic of mental health issues, but reacts to them</p> <p>18 as challenging behaviours. So I think it's all</p> <p>19 connected. You mentioned D812, for example --</p> <p>20 Q. 812.</p> <p>21 A. -- who was subject to a planned use of force because of</p> <p>22 his risk of self-harm. So in that case, it's absolutely</p> <p>23 clear that the perceived indication for the use of force</p> <p>24 was a mental health issue, which was self-harm. And</p> <p>25 then, when he was found, unfortunately, it was with</p> <p style="text-align: center;">Page 50</p>	<p>1 must have been distressed and frightened at that point</p> <p>2 when he was then subjected to the further use of force.</p> <p>3 Q. And the role of healthcare staff present at that stage</p> <p>4 should have been to raise a concern about an ongoing use</p> <p>5 of force or a contraindication to do so; is that right?</p> <p>6 A. Yes, absolutely. So the healthcare staff present should</p> <p>7 have said, "Stop", and tried to assess the situation,</p> <p>8 which means tried to assess his mental health and tried</p> <p>9 to engage him and to decide what was needed next. Now</p> <p>10 that the emergency had passed, they had time to do that.</p> <p>11 Q. I think, lastly, then -- we have touched on the use of</p> <p>12 segregation in D1527's case, I just want to ask about</p> <p>13 D2951 and the use of segregation to actually provide</p> <p>14 clinical care. At paragraph 163, you say that there do</p> <p>15 seem to be instances of segregation being used in</p> <p>16 a direct attempt to provide clinical care and protection</p> <p>17 for highly vulnerable detainees, and D2951 is one of</p> <p>18 those. He suffered from significant mental health</p> <p>19 issues and was maintained on rule 40 segregation in</p> <p>20 early June 2017 whilst awaiting transfer to</p> <p>21 a psychiatric unit. So given he was awaiting transfer</p> <p>22 to a psychiatric unit, he clearly was significantly</p> <p>23 mentally unwell?</p> <p>24 A. Yes.</p> <p>25 Q. He appears to have been accommodated in a medical</p> <p style="text-align: center;">Page 52</p>

<p>1 single-occupancy cell in E wing subject to a three-man 2 unlock. An IMB visitors report notes that E wing 3 officers were concerned that leaving him locked in 4 a room was detrimental. Would you also have been 5 concerned?</p> <p>6 A. Yes, absolutely. Leaving somebody alone in a room 7 amounts to solitary confinement, and the impact of that 8 on mental health is very clearly documented and known. 9 So his mental health was at risk, not just through the 10 prolonged increased isolation, but also due to the 11 actual circumstances of being held in a single room.</p> <p>12 Q. The Home Office continued to extend the authorisation 13 for rule 40 at each review until his ongoing care was 14 arranged, and during this period there were also 15 concerns raised by the detention staff that leaving him 16 in a locked room was detrimental to his mental state. 17 He was eventually transferred to a mental health unit 18 under section 48 on 15 June, but he appears to have come 19 back to Brook House in early August 2017. The use of 20 segregation in these type of circumstances, awaiting 21 a transfer or awaiting treatment, psychiatric treatment, 22 was an inappropriate use of segregation, in your view?</p> <p>23 A. Absolutely. I think that's particularly concerning 24 because now we are talking about the most unwell people 25 that are actually assessed as in need of admission to</p> <p style="text-align: center;">Page 53</p>	<p>1 environment. So we are talking about a failure of 2 safeguards to stop vulnerable people being in this 3 environment. Then we are talking about an environment 4 which has a known negative impact on mental health. So 5 where behaviours like self-harm, like distress, like 6 mental health problems are treated as challenging 7 behaviour, so an inappropriate response, that leads to 8 escalating mental health problems, increased risks of 9 self-harm. It's a perfect storm, and, in that 10 situation, we have people that are then unqualified to 11 manage. Their only recourse is use of force, solitary 12 confinement. They don't have the capacity to do 13 a therapeutic intervention. So the possible responses 14 are going to be inappropriate. I don't think it is 15 possible to separate that from the abuses that we see.</p> <p>16 MS SIMCOCK: Thank you. Chair, I don't have any further 17 questions for this witness. Do you have any questions 18 for her?</p> <p>19 THE CHAIR: I don't. Thank you very much for your evidence, 20 Dr Bingham. I know it is not necessarily an easy 21 experience but it's been very important to hear from 22 you.</p> <p>23 A. Thank you.</p> <p>24 MS SIMCOCK: Can I suggest quarter to?</p> <p>25 A. Indeed, thank you.</p> <p style="text-align: center;">Page 55</p>
<p>1 hospital.</p> <p>2 Q. It is clearly not a substitute for mental health 3 treatment?</p> <p>4 A. Well, it's not a mental health treatment at all. It is 5 actually -- it is worse than nothing, because it's 6 actually something that would harm his mental health. 7 So not only is it not therapeutic, but it is actually 8 going to contribute to his deterioration.</p> <p>9 Q. If someone is so unwell as to need to be segregated, 10 does that suggest they shouldn't be in detention in the 11 first place?</p> <p>12 A. Yes, absolutely, because, as I have said, that is 13 a harmful environment which is going to exacerbate their 14 mental health condition.</p> <p>15 Q. My last question before the break, I think, subject to 16 any questions the chair has, is, I'd like to just ask 17 for your view on any links between any of these failures 18 we have just discussed in some considerable detail and 19 the incidents we see of mistreatment captured on 20 Panorama?</p> <p>21 A. Thank you, yes. So I think it's impossible to really 22 separate these issues. We are talking about failures of 23 safeguards in rule 35(1), rule 35(2) and rule 35(3), 24 rule 40, which means that vulnerable people are not 25 picked up as vulnerable and they are kept in an</p> <p style="text-align: center;">Page 54</p>	<p>1 (The witness withdrew)</p> <p>2 (11.27 am)</p> <p>3 (A short break)</p> <p>4 (11.46 am)</p> <p>5 MS SIMCOCK: Chair, the next witness is Theresa Schleicher.</p> <p>6 MS THERESA VERONIKA PENNINGTON SCHLEICHER (affirmed)</p> <p>7 MS SIMCOCK: Can you give your full name, please.</p> <p>8 A. I have always worked as Theresa Schleicher. That's 9 actually my maiden name. So my full name is Theresa 10 Veronika Pennington Schleicher.</p> <p>11 Q. Thank you. You are the casework manager at Medical 12 Justice and have held that role since July 2009; is that 13 right?</p> <p>14 A. That's correct.</p> <p>15 Q. What does that role entail?</p> <p>16 A. I'm responsible for the individual casework we do. So 17 I do some casework myself and I have three caseworkers 18 working with me. We are the main point of contact for 19 our clients who are detained. We then allocate 20 clinicians who will carry out medico-legal assessments 21 and we co-ordinate any follow-up work that we do for 22 those clients. That might include advocating for them 23 to receive appropriate healthcare, referring them, for 24 instance, to legal representatives and making sure they 25 receive care in the community when they are released.</p> <p style="text-align: center;">Page 56</p>

<p>1 I also feed into policy work that we do in the</p> <p>2 organisations. So I have regular meetings with our</p> <p>3 policy team and I have attended a lot of stakeholder</p> <p>4 meetings with the Home Office and other relevant bodies.</p> <p>5 Q. What is the purpose of those stakeholder meetings?</p> <p>6 A. With the Home Office, it is for us to give feedback on</p> <p>7 how Home Office policies are working on the ground, what</p> <p>8 we see in our work with detained people, and also the</p> <p>9 Home Office will often ask for our input in</p> <p>10 consultations on new policies that are being brought in.</p> <p>11 Q. You say in your statement that your casework covers</p> <p>12 primarily three groups of people in detention: those who</p> <p>13 report torture, those who have a clinical problem and</p> <p>14 need an assessment of their treatment and support, and</p> <p>15 those who allege that they have been assaulted or</p> <p>16 subject to excessive force in detention or during an</p> <p>17 attempted removal; is that right?</p> <p>18 A. That's right, and of course there is overlap between</p> <p>19 those three groups.</p> <p>20 Q. How does Medical Justice receive referrals?</p> <p>21 A. Just over half of referrals are self-referrals by</p> <p>22 detained people who ring up, and most of the time they</p> <p>23 have heard about us by word of mouth from other people</p> <p>24 in detention. And the rest comes from a mixture of</p> <p>25 sources. There are a lot of referrals from legal</p> <p style="text-align: center;">Page 57</p>	<p>1 organisation to do that. So we prioritise on the basis</p> <p>2 of where we think our intervention is likely to make the</p> <p>3 biggest difference, and so, people who have survived</p> <p>4 torture, it is known that they are very likely to</p> <p>5 deteriorate in detention, so they are a priority.</p> <p>6 People who are very unwell, either mentally or</p> <p>7 physically, while in detention, again, they are</p> <p>8 a priority.</p> <p>9 Q. You say at paragraph 19 of your statement that</p> <p>10 Medical Justice maintains a bespoke database. How many</p> <p>11 cases are on that database, roughly?</p> <p>12 A. Oh, that's difficult to say. But we receive between 800</p> <p>13 and 1,000 referrals a year and we have had the database</p> <p>14 since, I think, 2009, so they are all on there, a lot of</p> <p>15 cases. Obviously, for those who we take on, there's</p> <p>16 much more information on there because we will continue</p> <p>17 to update it while we work off the person. For those</p> <p>18 where we are not able to take on the case, there is only</p> <p>19 relatively brief details on there.</p> <p>20 Q. What do you use the database for?</p> <p>21 A. To record our ongoing casework. So any time we have</p> <p>22 contact with that person, we'll record that; any steps</p> <p>23 we plan to take, we will record; what they tell us about</p> <p>24 their health, we record; and we upload their documents,</p> <p>25 so their healthcare records and any immigration</p> <p style="text-align: center;">Page 59</p>
<p>1 representatives and then from visitors groups, from</p> <p>2 other NGOs who work within detention -- that could be</p> <p>3 Hibiscus or any of the other NGOs -- and sometimes from</p> <p>4 family or friends of detained people, from clinicians</p> <p>5 that work within the community or from a range of other</p> <p>6 social workers.</p> <p>7 Q. What happens upon receipt of a referral? What's the</p> <p>8 process?</p> <p>9 A. We take their initial details and then they get</p> <p>10 allocated to one of our caseworkers who will speak with</p> <p>11 them more, find out what the help is that they are</p> <p>12 looking for. We will ask them for all of the documents</p> <p>13 they have with them to have an understanding of what's</p> <p>14 happened on their case so far. We will request their</p> <p>15 healthcare records and then we have regular casework</p> <p>16 meetings, at the moment three times a week, where we</p> <p>17 discuss those cases and decide what we can do for those</p> <p>18 clients.</p> <p>19 Q. Are you able to accept all referrals that come to you or</p> <p>20 is there a prioritisation?</p> <p>21 A. Unfortunately not. So we accept about a third of</p> <p>22 the referrals that come to us. The rest we will try to</p> <p>23 signpost to other organisations where we can. But in</p> <p>24 terms of providing medical assessment and evidence for</p> <p>25 people in detention, of course we are the only</p> <p style="text-align: center;">Page 58</p>	<p>1 documents we have.</p> <p>2 Q. Does it perform a function in your policy work as well?</p> <p>3 Does it feed into that?</p> <p>4 A. It does because it means we can then analyse themes that</p> <p>5 arise from the casework that we have done.</p> <p>6 Q. You talk in your statement about the policy context</p> <p>7 providing a backdrop for your casework and that that's</p> <p>8 that vulnerable people, Adults at Risk, should only be</p> <p>9 detained in exceptional circumstances; is that right?</p> <p>10 A. Exactly. I mean, that was accepted right from when the</p> <p>11 Detention Centre Rules first came in. It was made very</p> <p>12 clear that it was accepted that those who had survived</p> <p>13 torture or had mental health issues or other issues that</p> <p>14 made it very likely that they would deteriorate should</p> <p>15 not be put in detention because of that likelihood, so</p> <p>16 they should be screened out straight away either before</p> <p>17 entering detention or right after entering detention.</p> <p>18 Q. As you say, it is because that cohort of people may be</p> <p>19 particularly vulnerable to suffering harm in detention?</p> <p>20 A. Exactly.</p> <p>21 Q. In your view, mere immigration factors such as entering</p> <p>22 the UK illegally, overstaying or refusing to leave</p> <p>23 voluntarily couldn't, or shouldn't, constitute</p> <p>24 exceptional circumstances; is that right?</p> <p>25 A. Absolutely. And of course that was accepted by the</p> <p style="text-align: center;">Page 60</p>

<p>1 Home Office as well, until 2017 when the Adults at Risk 2 policy came in.</p> <p>3 Q. What, in your view, is the Adults at Risk framework and 4 the safeguards under rules 34 and 35 designed to 5 achieve?</p> <p>6 A. So rule 35 and rule 34 have been there since 2001 and 7 they were designed to identify vulnerable people at high 8 risk of harm in detention, for them to be identified 9 straight away on entering detention and to then be 10 released. So that they wouldn't stay in detention and 11 actually suffer harm. That process never really worked 12 and there was then a number of findings of severely 13 mentally ill people who suffered article 3 breaches 14 while in detention. There were also a number of deaths 15 that raised similar issues. Following that, 16 Stephen Shaw was commissioned to review the process of 17 detention for vulnerable people and the Adults at Risk 18 policy obviously came out of that. Shaw identified that 19 those safeguards weren't working effectively. He did 20 say that the premise of having these groups of people 21 that were identified who were at particular risk of harm 22 was a good one and that that should be preserved and 23 built on and he then suggested some additional 24 safeguards. That's what we expected the adults at risk 25 policy would do, but when it came out, actually it</p> <p style="text-align: right;">Page 61</p>	<p>1 detention. It tends to be a really brief assessment to 2 meet immediate health needs. For example, prescription 3 of medication. So that doesn't identify people at risk 4 of harm and, therefore, can't lead on to a rule 35 5 report. If people are identified at either the rule 34 6 stage or at the screening stage by a nurse, 7 unfortunately that now doesn't trigger a rule 35 report 8 immediately either. I think it used to more in about 9 2014. Those two rules seem to have become disconnected, 10 and so, instead of a rule 35 report being done straight 11 away, people are put on a rule 35 waiting list for 12 a later appointment.</p> <p>13 Q. We heard Dr Oozeerally talk about that on Friday. In 14 your view, that's inappropriate and the rule 34 process 15 should be leading to rule 35 reports immediately in 16 appropriate cases?</p> <p>17 A. Absolutely. The whole purpose of the two rules taken 18 together is to identify people immediately and route 19 them out of detention. So if, instead, a period is a -- 20 a waiting period is allowed, that means people may 21 deteriorate in the meantime.</p> <p>22 Q. Do you have experience in relation to your casework of 23 disclosures being made, for example, of being a victim 24 of torture either to the nurse or to the GP that 25 nevertheless didn't lead to a rule 35 assessment or</p> <p style="text-align: right;">Page 63</p>
<p>1 didn't do that and we were really concerned that, 2 instead, it looked like it was going to undermine the 3 safeguards.</p> <p>4 Q. In relation to defects in the rules 34 and 35 rules 5 system for safeguarding vulnerable detainees, as you 6 say, initially, at the outset of detention, but is there 7 a role for those on an ongoing basis in detention?</p> <p>8 A. Absolutely. I mean, I think it's really important that 9 people are screened and identified before they even 10 enter detention and that doesn't work, there is no 11 proper process for that, and then those who are missed 12 by that process to be identified as early as possible in 13 detention. But, of course, some will be missed by that 14 and so it's really important that there's ongoing 15 monitoring, and that's why rule 35 is an ongoing duty to 16 report people at risk of harm so they can then be routed 17 out of detention as quickly as possible.</p> <p>18 Q. What do you see as the main defects that remain in the 19 system of rule 34 currently?</p> <p>20 A. So rule 34. I think now most people, not all, but most 21 people, who arrive in detention are seen by a GP within 22 24 hours, but that isn't an examination that can meet 23 the purpose of rule 34. So it is not a targeted mental 24 and physical examination designed at eliciting 25 information about whether the person is at risk in</p> <p style="text-align: right;">Page 62</p>	<p>1 report at all?</p> <p>2 A. Yes, absolutely. We have seen that frequently.</p> <p>3 Q. In terms of the rule 34 assessment, or indeed rule 35 4 assessment, is there an appropriate focus by GPs on 5 mental health and vulnerabilities in those assessments?</p> <p>6 A. No. As far as we can see, mental health is often not 7 properly assessed and not properly recorded.</p> <p>8 Q. What's the consequence of that?</p> <p>9 A. Often that's the key evidence that really needs to go to 10 the Home Office and it means that that information isn't 11 considered when detention is reviewed, and so, often, it 12 means the person remains in detention when really they 13 should not.</p> <p>14 Q. Where rule 35 reports are being written, in your 15 experience, are they of an adequate quality?</p> <p>16 A. No. I think, often, important issues are left out that 17 would have been really important to cover. For example, 18 mental health symptoms. Sometimes comments are made 19 that are really easily misinterpreted, like "no severe 20 mental health issues" when there clearly are significant 21 mental health issues, or recently we have seen the term 22 "stable in detention" very frequently, which I think 23 just means no issues so acute as to require 24 hospitalisation. It doesn't mean no mental health 25 issues that are likely to deteriorate. So that really</p> <p style="text-align: right;">Page 64</p>

<p>1 gives a wrong picture of what the situation is for the</p> <p>2 client.</p> <p>3 Q. In those types of circumstances, would you be of</p> <p>4 the view that more rule 35(1) reports, for example,</p> <p>5 should be being written?</p> <p>6 A. Absolutely. I mean, the absence of rule 35(1) and</p> <p>7 rule 35(2) reports is a failure that just means those</p> <p>8 safeguards are non-existent in practice.</p> <p>9 Q. There really seems to be a focus primarily, if not</p> <p>10 exclusively, on rule 35(3); is that your experience?</p> <p>11 A. Absolutely. But I think the purpose of rule 35(3) is</p> <p>12 being misunderstood, in that it often gets referred to</p> <p>13 as things like "allegation of torture application". And</p> <p>14 it is not an application by the person in detention, it</p> <p>15 is a duty on the doctor to report concerns. It is only</p> <p>16 because that isn't being done as it should that it then</p> <p>17 starts to be viewed as an application and detained</p> <p>18 people are having to go and ask for one or have their</p> <p>19 solicitors enquire about it.</p> <p>20 Q. There seems to be an emphasis on a detainee seeking</p> <p>21 rule 35 reports rather than a view that there's an</p> <p>22 obligation on those on the other side of the equation to</p> <p>23 identify those people, make assessments and write -- and</p> <p>24 have GPs write reports. Is that right?</p> <p>25 A. Exactly. Absolutely.</p> <p style="text-align: center;">Page 65</p>	<p>1 groups arguing that they ought to have rule 35 reports</p> <p>2 because they fall within those groups is exactly what</p> <p>3 the purpose of rule 35 has always been intended to be.</p> <p>4 I don't see how that could be a misuse of it.</p> <p>5 Q. If the system was operating as it was meant to under the</p> <p>6 rule, it is not, we know it is failing. But if it is</p> <p>7 operating as it was meant to, there would be no need to</p> <p>8 advocate for those people because they would already</p> <p>9 have been picked up; is that right?</p> <p>10 A. Exactly. Exactly.</p> <p>11 Q. You also speak in your statement about a concern that</p> <p>12 there's no oversight mechanism to monitor the operation</p> <p>13 of the rule 35 process; is that right?</p> <p>14 A. That's right, yes. There are some limited statistics</p> <p>15 that are now being generated, but they are very much</p> <p>16 focused just on the numbers. There have been a few</p> <p>17 audit or dip sampling exercises that the Home Office has</p> <p>18 done. The first one was done after a lot of pressure</p> <p>19 from us and from other NGOs through the relevant</p> <p>20 stakeholder groups and the results of the sample were</p> <p>21 eventually lost.</p> <p>22 The second one was published but it was completely</p> <p>23 focused on the procedural aspects of it, so that</p> <p>24 revealed that a certain number of reports were being</p> <p>25 done. Some there were long delays in the response times</p> <p style="text-align: center;">Page 67</p>
<p>1 Q. And that's inappropriate?</p> <p>2 A. That's completely inappropriate because a lot of people</p> <p>3 won't seek a report, they won't know about it. They</p> <p>4 might only find out about it once they have already been</p> <p>5 in detention for a period of time, at which point they</p> <p>6 may have suffered harm. It also leads to a perception</p> <p>7 sometimes, I think, that detained people are in some way</p> <p>8 demanding when they ask for a rule 35 report or that</p> <p>9 they can't wait and that's unreasonable. But of course,</p> <p>10 they shouldn't be in that position in the first place.</p> <p>11 Q. Dr Oozeerally gave evidence about a misuse of</p> <p>12 the rule 35 system. Do you have any comment upon that</p> <p>13 evidence?</p> <p>14 A. Yes, I thought that was quite shocking, really. There</p> <p>15 was some reference to rule 35 having been changed or</p> <p>16 expanded in some way, and of course that's not the case.</p> <p>17 Rule 35 has been the same since it was brought in, in,</p> <p>18 I think, 2000 or 2001, and has always been intended to</p> <p>19 pick up those, to identify those, who are at risk of</p> <p>20 deteriorating in detention. By reference to these</p> <p>21 protected groups who were set out in the previous policy</p> <p>22 as protected groups, that's now been converted into</p> <p>23 indicators. Because it's known that they would be</p> <p>24 particularly at risk and that's always included torture</p> <p>25 survivors. So those people seeking rule 35 reports or</p> <p style="text-align: center;">Page 66</p>	<p>1 and a significant number were completely lost and never</p> <p>2 responded to. Later, there were some dip sampling</p> <p>3 exercises that the Home Office did. What was never</p> <p>4 looked at was the content and why they weren't leading</p> <p>5 to release and what was happening to those people in</p> <p>6 whose cases it didn't lead to release, whether they were</p> <p>7 deteriorating, and that really is needed.</p> <p>8 Q. So there's some limited audit of the numbers of rule 35</p> <p>9 reports; is that right?</p> <p>10 A. Yes, numbers of rule 35 reports broken down both by</p> <p>11 centre and by type, so (1), (2), (3), and then numbers</p> <p>12 of releases.</p> <p>13 Q. But no further follow-up as to what happened in the</p> <p>14 cases that weren't released?</p> <p>15 A. Exactly and also no analysis of the content of</p> <p>16 the reports. So, for instance, does it lead to</p> <p>17 detention being maintained if the doctor fails to</p> <p>18 comment on mental health? Those sorts of questions</p> <p>19 would be important to ask.</p> <p>20 Q. So it is about the quality of the report?</p> <p>21 A. The quality of the reports and the quality of</p> <p>22 the subsequent detention review.</p> <p>23 Q. Have you raised those concerns with the Home Office?</p> <p>24 A. Yes, we have raised them consistently. When I first</p> <p>25 started in 2009, I immediately started attending the DUG</p> <p style="text-align: center;">Page 68</p>

<p>1 and DUG medical subgroups, stakeholder groups -- that</p> <p>2 stands for "detention users group" -- and that was the</p> <p>3 main stakeholder group at the time for dealing with</p> <p>4 issues related to detention. That was attended by the</p> <p>5 Home Office, by Phil Schoenenberger and Simon Barrett,</p> <p>6 and then, later, that got subsumed into the NASF --</p> <p>7 National Asylum Stakeholder Forum -- detention subgroup.</p> <p>8 Through these forums, and also in writing, we have,</p> <p>9 since 2009, raised these concerns repeatedly and have</p> <p>10 brought examples of how it fails, we have published</p> <p>11 several reports that touch on this and have brought this</p> <p>12 to the attention of the Home Office, but no effective</p> <p>13 action has been taken.</p> <p>14 Q. What was their response?</p> <p>15 A. When we bring examples, often we get told it is not</p> <p>16 possible to comment on things like that in such detail</p> <p>17 and that those are just individual cases and it wouldn't</p> <p>18 be appropriate to discuss them. When we bring general</p> <p>19 concerns, we are often told that these are too general</p> <p>20 and specific examples are required. At one point, there</p> <p>21 was an admission that there has been a disconnect</p> <p>22 between the doctor writing the report and the</p> <p>23 Home Office receiving them. But then no action was</p> <p>24 taken to address that disconnect. Forms were changed at</p> <p>25 one point and there was some consultation in relation to</p> <p style="text-align: center;">Page 69</p>	<p>1 Q. In relation to the definition of torture, we have heard</p> <p>2 that it changed. It was originally restricted to</p> <p>3 actions by estate agents and then it changed thereafter.</p> <p>4 A. It was -- sorry. I don't mean to interrupt.</p> <p>5 Q. Is there any concern about the current definition of</p> <p>6 torture in relation to rule 35?</p> <p>7 A. So originally, the definition was wide. It wasn't</p> <p>8 restricted to estate actors. It was never specifically</p> <p>9 defined originally, but it was always understood by</p> <p>10 everyone to be very wide and that's because a wide range</p> <p>11 of people are vulnerable to suffering harm in detention.</p> <p>12 So who the perpetrator of torture was, for instance,</p> <p>13 clinically -- I'm not a clinician, but I understand from</p> <p>14 the clinical literature that that is not relevant to</p> <p>15 what harm it causes. So it was always very wide. Then</p> <p>16 in about 2012, there was a few Medical Justice clients</p> <p>17 challenged their detention in the courts. The case was</p> <p>18 later reported as EO. While that case was going on,</p> <p>19 the Home Office decided to limit the definition to</p> <p>20 UNCAT -- United Nations Convention Against Torture</p> <p>21 definition -- which is specific to torture that happens</p> <p>22 with -- either by estate actors or with the acquiescence</p> <p>23 of the state, and they used that to try to justify why,</p> <p>24 in some of the cases of those clients who brought those</p> <p>25 cases, why there hadn't been rule 35 reports. The</p> <p style="text-align: center;">Page 71</p>
<p>1 that and we raised some concerns about the forms but</p> <p>2 they were effectively ignored.</p> <p>3 Q. What were your concerns about the forms?</p> <p>4 A. So in 2015, the form -- previously there was one form</p> <p>5 with tick boxes for rule 35(1), (2) or (3) and that was</p> <p>6 changed to three separate templates. We were worried</p> <p>7 there was a possibility that having these three forms</p> <p>8 may deter doctors from filling them in.</p> <p>9 Q. Which seems to have been the case.</p> <p>10 A. Which seems to have happened. We were also worried that</p> <p>11 the questions that were being asked may mislead the</p> <p>12 doctors into thinking the thresholds were higher than</p> <p>13 they actually were, which, again, is something that</p> <p>14 appears to have happened. I noticed that a couple of</p> <p>15 witnesses referred to the questions on the form</p> <p>16 indicating to them that there were certain steps they</p> <p>17 should take to monitor whether deterioration was</p> <p>18 occurring. And, of course, that goes entirely against</p> <p>19 the purpose of the rule, which is to identify people</p> <p>20 pre-emptively before harm occurs.</p> <p>21 Q. Yes.</p> <p>22 A. We also recommended -- we were -- we saw some of</p> <p>23 the training slides, not all of them. We were concerned</p> <p>24 about the content of that and we recommended audit and</p> <p>25 monitoring and that wasn't put in place.</p> <p style="text-align: center;">Page 70</p>	<p>1 Home Office, at that point, argued that the definition</p> <p>2 had always been UNCAT but that was found not to be</p> <p>3 correct and, certainly, our experience was that was not</p> <p>4 correct. It was previously always wide. The judgment</p> <p>5 then said that, one, it had always been wider and, two,</p> <p>6 also there was no clinical basis for narrowing it,</p> <p>7 because the impact on people who weren't covered by</p> <p>8 UNCAT torture but were covered by a wider definition was</p> <p>9 the same, it was -- detention was likely to be very</p> <p>10 harmful to them.</p> <p>11 After that judgment, the Home Office didn't</p> <p>12 implement that straight away so we had to send another</p> <p>13 letter threatening legal action until that was</p> <p>14 implemented. Despite this judgment having already found</p> <p>15 that there was no basis for narrowing the definition,</p> <p>16 the Home Office then sought to narrow it again with the</p> <p>17 Adults at Risk policy.</p> <p>18 So I understand that witnesses have said that it was</p> <p>19 confusing, these changes. I think they probably were</p> <p>20 confusing and we were really concerned at the time that,</p> <p>21 one, they didn't reflect the clinical evidence and</p> <p>22 excluded people who were very vulnerable, but also that</p> <p>23 the narrower definition is confusing and difficult to</p> <p>24 apply. What happens with the acquiescence of</p> <p>25 the state -- it is a very complex question in lots of</p> <p style="text-align: center;">Page 72</p>

<p>1 cases and not one that GPs and detention centres are in</p> <p>2 a position to address correctly.</p> <p>3 Q. You have also referred to the satisfactory management in</p> <p>4 detention threshold in relation to detainees who are</p> <p>5 unwell, a test that was effectively meant to be</p> <p>6 abolished following the recommendations made by the</p> <p>7 Shaw Review. Does there remain a concern about</p> <p>8 detainees who are unwell being managed in detention?</p> <p>9 A. Absolutely. So this satisfactory management provision</p> <p>10 was exactly what led to those article 3 cases. Those</p> <p>11 were cases of mentally ill people who were allowed to</p> <p>12 deteriorate in detention because it was deemed that they</p> <p>13 could be satisfactorily managed. So that's the kind of</p> <p>14 level of harm that that caused. And in the aftermath of</p> <p>15 that, Shaw published his report and recommended a return</p> <p>16 to the category-based provision. Formally, the wording,</p> <p>17 "satisfactorily management" disappeared out of</p> <p>18 the policy. It doesn't appear in the Adults at Risk</p> <p>19 policy, but the way that that's constructed has</p> <p>20 essentially brought it in across the board. So level 3,</p> <p>21 which is what detainees have to get to, the evidence</p> <p>22 that they need to provide, to benefit from strong</p> <p>23 protection against detention, is to show that they would</p> <p>24 be -- that detention would be causing harm. And in</p> <p>25 practice, it seems to often be applied as it has already</p> <p style="text-align: center;">Page 73</p>	<p>1 Q. In 2019, the Home Office suggested widening the scope of</p> <p>2 who could make rule 35 reports. They suggested that it</p> <p>3 didn't need to only be a GP who could write a rule 35</p> <p>4 report. What's your view about that suggestion?</p> <p>5 A. I think it's really important that there is, overall,</p> <p>6 someone who is trained to be able to do this, who has</p> <p>7 the responsibility for it, so that other staff can</p> <p>8 report to that person. I don't see a problem in</p> <p>9 psychiatrists, for instance, being able to prepare</p> <p>10 rule 35 reports, but I think it is really important</p> <p>11 there is someone, like the GP, who is the prime</p> <p>12 responsible person for this, to make sure that it does</p> <p>13 actually happen. The other thing that was also proposed</p> <p>14 at the same time is not only that a wider range of</p> <p>15 professionals could complete the reports, but also</p> <p>16 rule 34 was being proposed to be downgraded to simply an</p> <p>17 appointment rather than specifically it being a mental</p> <p>18 and physical examination. When we queried this, we were</p> <p>19 told by the Home Office that, yes, of course there was</p> <p>20 going to be an examination, but we were really worried</p> <p>21 about this because, of course, at the moment, what we</p> <p>22 are seeing is that there isn't a proper examination</p> <p>23 taking place.</p> <p>24 Q. Even though one is required under the rule?</p> <p>25 A. Exactly. So we can only imagine what would happen if it</p> <p style="text-align: center;">Page 75</p>
<p>1 caused harm or would be likely to cause harm within</p> <p>2 a very short period. So that's essentially the same</p> <p>3 provision now applied across all vulnerabilities,</p> <p>4 including torture survivors.</p> <p>5 Q. So it is described differently, but, in your view, it is</p> <p>6 exactly the same test that's being applied?</p> <p>7 A. Exactly, and it has been made integral to the way that</p> <p>8 the whole safeguard works.</p> <p>9 Q. You heard the evidence of Dr Oozeerally and</p> <p>10 Dr Chaudhary, I believe, on Friday. They talked about</p> <p>11 the management of ill-health in Brook House and in</p> <p>12 particular that rule 35(1) reports were not being</p> <p>13 written if detainees could be managed in detention. Do</p> <p>14 you have any comment upon that practice that seems to be</p> <p>15 ongoing by them in Brook House?</p> <p>16 A. Yes. I think that's -- that's exactly the practice that</p> <p>17 led to us seeing those breaches of article 3 and the</p> <p>18 terrible harm that was caused to those detainees. What</p> <p>19 I'm quite shocked about is that those doctors don't seem</p> <p>20 to appreciate that there is a lot of evidence that</p> <p>21 mental illness can't be effectively managed in</p> <p>22 detention. So there is not much that can then be done</p> <p>23 for those detained people who are deteriorating. At</p> <p>24 very best, what healthcare is able to do is accompany</p> <p>25 their deterioration.</p> <p style="text-align: center;">Page 74</p>	<p>1 wasn't required.</p> <p>2 Q. Otherwise, at least at that time, there were no other</p> <p>3 proposals for change to rule 35, despite Shaw's</p> <p>4 recommendation that there be a complete overhaul of that</p> <p>5 rule. What's your view about what should happen to</p> <p>6 rule 35 in the future?</p> <p>7 A. It's never worked effectively. There have been lots of</p> <p>8 recommendations relating to it for a decade, and still</p> <p>9 no effective change appears to have been possible. I'm</p> <p>10 not sure that that is because rule 35 in itself, the way</p> <p>11 it is written, is deficient in some way. I think, in</p> <p>12 theory, rule 34 and rule 35 could play a really</p> <p>13 important role. I think there are lots of factors that</p> <p>14 feed into why it hasn't worked so far. Part of it,</p> <p>15 I think, is that it's never been properly prioritised.</p> <p>16 I think the culture of disbelief that exists both within</p> <p>17 the Home Office and within healthcare has fed into that.</p> <p>18 And I think there hasn't been the will within the</p> <p>19 Home Office to make proper changes to these safeguards.</p> <p>20 The only explanation we have been able to come up with</p> <p>21 for why that is is because the Home Office has just not</p> <p>22 been sufficiently interested in prioritising the welfare</p> <p>23 of vulnerable people in detention. The information has</p> <p>24 been on the table for a very long time, but I think</p> <p>25 instead removals and throughput through detention onto</p> <p style="text-align: center;">Page 76</p>

<p>1 the plane has been consistently prioritised.</p> <p>2 Q. You've heard the way that Dr Oozeerally and Dr Chaudhary</p> <p>3 are applying rule 35 within Brook House, even currently.</p> <p>4 A. Yes.</p> <p>5 Q. Particularly that they are not conducting rule 35 -- not</p> <p>6 completing rule 35(2) reports and it seems, still, very</p> <p>7 few rule 35(1) reports. That's still clearly a concern?</p> <p>8 A. Yes, that's still clearly a concern and that disables</p> <p>9 those safeguards, effectively. Because, of course,</p> <p>10 unless concerns are being reported to the Home Office,</p> <p>11 the Adults at Risk policy can't be applied. It is also</p> <p>12 an example of how lessons are not being learned. For</p> <p>13 example, rule 35(2) was a feature in several inquests</p> <p>14 that were reported but that information doesn't seem to</p> <p>15 be identified and fed back for those -- to those who</p> <p>16 work within the system.</p> <p>17 Q. The concerns aren't just restricted, though, to the lack</p> <p>18 of rule 35(2) reports and rule 35(1) reports. The</p> <p>19 system, even under rule 35(3), doesn't appear to</p> <p>20 function adequately. What do you see as the main</p> <p>21 deficiencies in that part of the system currently?</p> <p>22 A. On rule 35(3)?</p> <p>23 Q. Yes.</p> <p>24 A. So one aspect is what we have already touched on, the</p> <p>25 connection between rule 35(4) and rule 35(5) -- rule 35</p> <p style="text-align: center;">Page 77</p>	<p>1 concerns underlying it. Again, that's not conducive to</p> <p>2 trust and full disclosure.</p> <p>3 When a report is then done, often the information is</p> <p>4 already known to healthcare. It is recorded in the</p> <p>5 healthcare records. It is often not reflected in the</p> <p>6 report. I think that appears in a couple of the case</p> <p>7 studies we have put together. Often clients will have</p> <p>8 presented repeatedly with significant symptoms to</p> <p>9 healthcare, those are recorded, but still the rule 35</p> <p>10 report doesn't pick them up, doesn't analyse them in any</p> <p>11 way or link them to what the impact of detention might</p> <p>12 be. So if someone is starting to experience symptoms of</p> <p>13 PTSD, I'm not a clinician, but it doesn't seem to be</p> <p>14 a big jump to think that that's likely to deteriorate</p> <p>15 but that question doesn't seem to be asked. The</p> <p>16 question of the lurking impact of detention is often not</p> <p>17 addressed.</p> <p>18 Q. So the quality of the reports remains a concern --</p> <p>19 A. Remains a real concern --</p> <p>20 Q. -- under rule 35(3)?</p> <p>21 A. -- yes.</p> <p>22 Q. Does that have a knock-on effect on the rates of</p> <p>23 release, in your view?</p> <p>24 A. Absolutely. So the rates of release are low and have</p> <p>25 always been low.</p> <p style="text-align: center;">Page 79</p>
<p>1 that has disappeared. Then there is the issue that</p> <p>2 disclosures -- first, there is an issue with eliciting</p> <p>3 disclosure. So the expectation seems to be that</p> <p>4 a disclosure of torture would be made at the nurse</p> <p>5 screening, which can happen at any time during the day</p> <p>6 or night, in situations where the detained person is</p> <p>7 likely to be scared, bewildered, has just found</p> <p>8 themselves in a detention centre, so it is not</p> <p>9 a conducive environment for disclosures. If disclosure</p> <p>10 doesn't happen at that point, there is no follow-up</p> <p>11 that's sort of automatic. It's then relied on that the</p> <p>12 detained person will come forward themselves. If</p> <p>13 disclosure does happen, it may lead to a rule 35</p> <p>14 appointment or it may not. If it does lead to an</p> <p>15 appointment, there is then a waiting time.</p> <p>16 Later on, if the client comes forward and discloses</p> <p>17 torture, again, sometimes it leads to a rule 35</p> <p>18 appointment, and sometimes it doesn't, and again there</p> <p>19 are waits. When the report is being done, a lot of</p> <p>20 clients report to us that it's -- they feel like they</p> <p>21 are rushed, they feel like the doctor doesn't believe</p> <p>22 them, isn't interested, sometimes clients report that</p> <p>23 they had the impression that the doctor thought that</p> <p>24 they were in some way wanting to use this for their</p> <p>25 immigration case and that there weren't clinical</p> <p style="text-align: center;">Page 78</p>	<p>1 Q. That's not a trend that's changing in any way?</p> <p>2 A. It doesn't appear to. I mean, sometimes they have</p> <p>3 increased slightly only to dip again.</p> <p>4 Q. Further Adults at Risk reform proposals were circulated,</p> <p>5 you say in your statement, by Ian Cheeseman</p> <p>6 in August 2020. Is that right?</p> <p>7 A. That's correct, yes.</p> <p>8 Q. Those did suggest a widening of reporting under rule 35</p> <p>9 to the full range of vulnerabilities covered in the</p> <p>10 Adults at Risk policy. What's your view about that</p> <p>11 change proposed?</p> <p>12 A. I think it is important that rule 35 is widened to the</p> <p>13 full range of indicators, but the problem with the</p> <p>14 proposal was that it didn't seem to want to focus on the</p> <p>15 indicators, but the idea was that, instead, it would</p> <p>16 focus purely on the impact of detention, and of course</p> <p>17 that's the bit that GPs are currently not adequately</p> <p>18 reporting. So we'd be really worried that it would</p> <p>19 instead entrench this sort of wait-and-see approach that</p> <p>20 we have seen.</p> <p>21 Q. It was proposed that the evidence levels of (1), (2) and</p> <p>22 (3) under the Adults at Risk policy would be replaced by</p> <p>23 risk levels indicating low, medium and high risk of</p> <p>24 suffering harm in detention. What's your view about</p> <p>25 that?</p> <p style="text-align: center;">Page 80</p>

<p>1 A. I think that's really dangerous. I think the problem is 2 that it's -- I mean, I'm not a clinician, but 3 I understand from our volunteer clinicians and my 4 colleagues that it's really difficult to predict who 5 will suffer harm and in what timeframe. The best guide, 6 I think, that clinicians have to make that decision is 7 the groups that we know from research are particularly 8 at harm -- at risk of harm. So survivors of torture, 9 those with a pre-existing mental illness and so on. 10 So I think going further down the route of having 11 very specific assessments of who is going to suffer what 12 harm within what timeframe is not going to work because 13 it is just not possible to make accurate assessments of 14 that. Instead, what we think is necessary is to return 15 to the original policy of having categories where it's 16 known that they're at risk and then routing those people 17 out of detention from the outset and not trying to see 18 who is going to deteriorate how quickly, because then we 19 get into the situation of -- I think Dr Hard may have 20 suggested that it would be better to wait and observe 21 and monitor and then document harm that's already 22 occurred. 23 Q. It's certainly easier to do that. 24 A. I'm sure it's easier to do, but of course, then, 25 preventable harm has occurred and we have talked a lot</p> <p style="text-align: center;">Page 81</p>	<p>1 that would then effectively automatically trigger 2 rule 35 and release from detention thereafter unless 3 there were the most exceptional circumstances? 4 A. Exactly. I think it would need to be combined with the 5 most exceptional circumstances threshold for release. 6 I think it would also need to be combined with effective 7 pre-detention screening. I think there has been a lot 8 of -- the doctors have given evidence that there is 9 a lot of pressure on rule 35 in terms of time and, of 10 course, part of the reason for that is that there are 11 a lot of vulnerable people in detention. 12 Q. Yes. In relation to that screening prior to detention, 13 in your view, the gatekeeper role used as a screening 14 tool to assess vulnerability is a weak screening tool; 15 is that right? 16 A. Yes, because there is no external input into it. It is 17 purely internal. There is also no opportunity for the 18 person who is about to be detained or their 19 representatives to submit any information, so we have 20 seen it to be quite ineffective. 21 Q. Is there a concern about how the balancing exercise of 22 immigration factors against vulnerabilities is being 23 conducted? 24 A. That as well, and that comes back to the problem that we 25 have seen throughout this, which is that the Home Office</p> <p style="text-align: center;">Page 83</p>
<p>1 about people deteriorating. I mean, I think it's 2 helpful to remind ourselves what an awful distressing 3 situation that is. Dr Bingham described what flashbacks 4 are like. Some of the descriptions we have heard of 5 what people have been like in detention, what they have 6 felt, utterly, utterly terrifying and the harm often 7 lasts long beyond detention. So if that can be 8 prevented it certainly must. 9 Q. The further proposal in August 2020 was that the 10 rule 35(1), (2) and (3) separate forms would be replaced 11 again by a single form focused upon assessing the 12 likelihood of the person being harmed in direction. You 13 have talked about how really focusing on the likelihood 14 of harm is not what, in your view, should happen. Would 15 a single form though assist? 16 A. I think a single form may assist. Although rule 35 has 17 never worked and there used to be a single form. 18 Q. So it wouldn't be -- 19 A. So it is probably helpful to have great forms but 20 I think tinkering with the mechanisms isn't going to 21 solve the problem. 22 Q. In your view, the best proposal for change in relation 23 to rule 35 would be to return to a category-based 24 approach that covered all the relevant categories that 25 are currently in the Adults at Risk policy, but that</p> <p style="text-align: center;">Page 82</p>	<p>1 appears to, at every turn, prioritise removal over 2 welfare. In one of the most -- more recent case studies 3 that I appended to my statement is one of a man called 4 HRB -- sorry, I need to deduce the initials from the 5 name -- who was recognised as level 3 at the point he 6 was detained. The gatekeeper authorised detention. It 7 said reluctantly and only until scheduled removal, which 8 was shortly after, and it was clear this man should have 9 been released immediately when removal didn't take 10 place. But when people enter detention, they get stuck 11 in detention, and he remained in detention for a long 12 period of time, deteriorated, as was expected, and that 13 was completely foreseeable right from the beginning. 14 Q. There is a DSO04 from 2020 called "Mental vulnerability 15 and detention". Does that DSO in any way address your 16 concerns? 17 A. No. 18 Q. Why not? 19 A. So that DSO was proposed in the aftermath of the case of 20 VC, which was the case of a severely mentally ill man at 21 Brook House who was in segregation for long periods and 22 suffered very distressing symptoms and didn't have 23 capacity, and so he couldn't challenge his detention or 24 the circumstances in which he was being held, force that 25 was being used, him being in segregation. And so the</p> <p style="text-align: center;">Page 84</p>

<p>1 court identified that it was unlawful and discriminatory</p> <p>2 that there was no provision of independent advocacy to</p> <p>3 people in his situation. Nothing then happened until</p> <p>4 about 2019 when the first draft DSO was circulated for</p> <p>5 consultation, and, as often is the case, we were given</p> <p>6 a very short period of time to respond to it and some</p> <p>7 other relevant groups were not initially consulted,</p> <p>8 including the Royal College of Psychiatrists, and that</p> <p>9 draft DSO made no provision for that gap that had been</p> <p>10 specifically identified by the courts of the need for</p> <p>11 independent advocacy. We raised concerns about that and</p> <p>12 there was a bit of back and forth and another</p> <p>13 consultation a year later and, eventually, the DSO that</p> <p>14 he referred to was published and, again, that gap has</p> <p>15 not been filled and remains unchanged. So the DSO</p> <p>16 failed to address the main issue that was identified.</p> <p>17 Q. So there remains, in your view, a gap in the safeguards</p> <p>18 in relation to those detainees who may lack the mental</p> <p>19 capacity to make decisions about their detention, their</p> <p>20 medical treatment in detention and other types of</p> <p>21 decisions?</p> <p>22 A. Exactly. We continue to see people in detention,</p> <p>23 including at Brook House, including in the last few</p> <p>24 months, who lack capacity and who are not swiftly</p> <p>25 identified and assessed and who, even if they are</p> <p style="text-align: center;">Page 85</p>	<p>1 Q. They are effectively disregarded if they don't meet</p> <p>2 every single tick box?</p> <p>3 A. Exactly and some of the tick boxes don't have anything</p> <p>4 to do with the quality of the report. So, for example,</p> <p>5 one of them is that the same day the clinician, if they</p> <p>6 had concerns about the impact of detention, wrote</p> <p>7 a letter to the detention centre healthcare raising</p> <p>8 their concerns. A lot of the time, it is a good thing</p> <p>9 to send a letter straight away, but it doesn't have</p> <p>10 anything to do with the quality of the report. So we</p> <p>11 have, for example, come across a client, and he is also</p> <p>12 annexed as a case study, who was very unwell. He had</p> <p>13 severe PTSD and depression, he was deteriorating, he was</p> <p>14 suicidal. He was seen by an independent consultant</p> <p>15 psychiatrist arranged by his solicitor. This was</p> <p>16 a psychiatrist who didn't have experience of working</p> <p>17 within detention, so he was just unaware of</p> <p>18 the standards. He wrote a report, which was good, as</p> <p>19 you would expect from an experienced consultant</p> <p>20 psychiatrist, raising really serious concerns about the</p> <p>21 likelihood that this person was going to deteriorate</p> <p>22 even further in detention. But because he was unaware</p> <p>23 of the standards, he didn't meet them. So he didn't</p> <p>24 send that letter to healthcare the same day. Instead,</p> <p>25 he wrote his report really promptly and forwarded it to</p> <p style="text-align: center;">Page 87</p>
<p>1 assessed, there is no provision for them.</p> <p>2 Q. We heard from a witness from Freedom from Torture of</p> <p>3 quality standards in relation to medical reports</p> <p>4 provided to the Home Office on behalf of detainees and</p> <p>5 that those standards set too high a hurdle because they</p> <p>6 increased the standard of proof of professional medical</p> <p>7 evidence of vulnerability where that's from an</p> <p>8 independent person and not a practitioner working in an</p> <p>9 IRC. Is that your view also?</p> <p>10 A. Absolutely. And I think those standards -- the</p> <p>11 introduction of those standards are a good example of</p> <p>12 the suspicion that existed in the Home Office of any</p> <p>13 safeguard that turns up a lot of people. This was</p> <p>14 looked at also by ICIBI who asked for the evidence. The</p> <p>15 Home Office said there was abuse of the safeguard that</p> <p>16 provides for MLRs -- medico-legal reports -- that apply</p> <p>17 the Istanbul Protocol being automatically level 3. And</p> <p>18 we haven't seen the evidence and neither has the ICIBI,</p> <p>19 even though they have asked for it, of that abuse.</p> <p>20 What the Home Office has done to tackle this alleged</p> <p>21 abuse is to introduce these standards -- they are like</p> <p>22 a tick box. If a report doesn't meet all of</p> <p>23 the standards, then it is given less weight and often</p> <p>24 that means no weight in considering the detained</p> <p>25 person's detention.</p> <p style="text-align: center;">Page 86</p>	<p>1 the client's solicitor so that action could be taken</p> <p>2 promptly. But that wasn't enough and the report was</p> <p>3 disregarded. As a result, the client remained in</p> <p>4 detention for another month without this information</p> <p>5 being taken into account, until one of our doctors --</p> <p>6 actually, Dr Bingham -- went in and saw him again and</p> <p>7 did a report in accordance with the standards. But that</p> <p>8 delay of that information being considered was</p> <p>9 completely unnecessary.</p> <p>10 Q. You also comment in your statement that the standards</p> <p>11 entrench the practice of asking whether mental illness</p> <p>12 can be satisfactorily managed in detention. Is that</p> <p>13 right?</p> <p>14 A. So the standards require the writer to consider whether</p> <p>15 the provision of healthcare on site makes any difference</p> <p>16 and require the writer to immediately communicate with</p> <p>17 healthcare so that healthcare can attempt to manage</p> <p>18 anything that has been found. That was one of</p> <p>19 the points that was criticised in that consultant</p> <p>20 psychiatrist's report that I have just referred to, that</p> <p>21 he didn't specifically refer to what treatment was</p> <p>22 available in the detention centre. What was quite clear</p> <p>23 from his report was that the client couldn't be managed</p> <p>24 in the detention centre. So the particular detail of</p> <p>25 what treatment and what staff were available didn't make</p> <p style="text-align: center;">Page 88</p>

<p>1 any difference. But, yes, the underlying assumption is</p> <p>2 that most things can be managed.</p> <p>3 Q. That underlying assumption is wrong, in your view?</p> <p>4 A. Exactly. And all the evidence, as Dr Bingham has</p> <p>5 explained, all the clinical evidence available shows</p> <p>6 that that assumption is wrong.</p> <p>7 Q. You also comment in your statement at paragraphs 173 to</p> <p>8 174 on the prevalence of use of force remaining</p> <p>9 a serious concern for the IMB 2020 report on</p> <p>10 Brook House. As far as you're concerned, is the use of</p> <p>11 force still a concern in Brook House?</p> <p>12 A. Yes, absolutely. I think we see more of it when the</p> <p>13 detention centre fills up more and possibly a bit less</p> <p>14 of it when there are slightly lower numbers, but it</p> <p>15 continues to be a concern. I think it will always</p> <p>16 remain a concern, because, if you have high numbers of</p> <p>17 vulnerable people, who may present as distressed, who</p> <p>18 may self-harm, who may have disturbed behaviour, and you</p> <p>19 can't effectively manage their mental health, then you</p> <p>20 will get behaviours that, in the staff there -- the only</p> <p>21 response to that available to them are the use of force</p> <p>22 and moving to E wing or to segregation, and of course</p> <p>23 that's often accompanied by the use of force. So</p> <p>24 I think that's something that you -- that will always --</p> <p>25 that's inherent in the way that this is set up.</p> <p style="text-align: center;">Page 89</p>	<p>1 either unwilling or unable to address that. So because</p> <p>2 of that, we see the only solution to deal with the harm</p> <p>3 that detention is causing on vulnerable people's health</p> <p>4 is to close them down. I don't think that's</p> <p>5 unreasonable. We are not the only organisation to</p> <p>6 propose that. The other main medical organisation who</p> <p>7 has considered this is the BMA and they have also</p> <p>8 recommended that immigration detention should be phased</p> <p>9 out. Other organisations have also thought that the</p> <p>10 safeguards aren't able to deal with the harm caused by</p> <p>11 detention adequately and that a time limit is needed.</p> <p>12 I think pretty much any body/organisation that has</p> <p>13 recently considered this issue has either recommended</p> <p>14 a fixed time limit or an end to immigration detention.</p> <p>15 I think even Dr Oozeerally himself recommended a limit</p> <p>16 of seven days.</p> <p>17 Q. So your main proposals for change, your preference,</p> <p>18 would be to phase out the use of detention altogether,</p> <p>19 given the harm you have seen that it causes in</p> <p>20 vulnerable people?</p> <p>21 A. (Witness nods).</p> <p>22 Q. Or if not to phase it out completely, to limit the power</p> <p>23 to detain and in particular to put a time limit on</p> <p>24 detention?</p> <p>25 A. (Witness nods).</p> <p style="text-align: center;">Page 91</p>
<p>1 Q. Yes, and use of force in relation to incidents of</p> <p>2 self-harm remains a concern?</p> <p>3 A. Exactly, and the percentage of the use of force that was</p> <p>4 aimed at stopping self-harm was reported in the IMB</p> <p>5 report to have gone up. I think it was a third of</p> <p>6 incidents of the use of force that were for that</p> <p>7 purpose. But, of course, we know from the 2017 case</p> <p>8 studies and from more recent cases that when force is</p> <p>9 used to stop self-harm, it often doesn't stop at that.</p> <p>10 Q. It was 37 per cent, in fact, so slightly more than</p> <p>11 a third --</p> <p>12 A. So even more than that.</p> <p>13 Q. -- but good memory. Dr Oozeerally in his evidence on</p> <p>14 Friday made a suggestion that Medical Justice is</p> <p>15 motivated by a political agenda, that immigration</p> <p>16 detention should be ended per se. Do you have any</p> <p>17 comment on that suggestion?</p> <p>18 A. Yes, thank you for giving me the opportunity to respond</p> <p>19 to that. We do believe that detention -- immigration</p> <p>20 detention should be ended, but that is not a political</p> <p>21 view, that is based on our experience and that of our</p> <p>22 clinicians of working with people in detention and</p> <p>23 seeing the impact that detention has on their mental</p> <p>24 health. It is based on seeing how the safeguards have</p> <p>25 consistently failed and how the Home Office has been</p> <p style="text-align: center;">Page 90</p>	<p>1 Q. Assuming neither of those two things happens or is</p> <p>2 likely to happen in the immediate future, I think you</p> <p>3 make some recommendations or some suggestions for</p> <p>4 changes given immigration detention continuing, and some</p> <p>5 of them are set out in some detail in Emma Ginn's</p> <p>6 statement, who is the director of Medical Justice; is</p> <p>7 that right?</p> <p>8 A. That's right, yes.</p> <p>9 Q. I just want to ask you about some of them on her behalf.</p> <p>10 If you can't answer, please do just say.</p> <p>11 A. Of course.</p> <p>12 Q. They are contained in Ms Ginn's statement, which we will</p> <p>13 adduce in full. You say that detention -- or she says,</p> <p>14 I should say, detention should be a last resort and that</p> <p>15 all alternatives should be exhausted first, prior to</p> <p>16 detaining someone; is that right?</p> <p>17 A. Absolutely. I think the only change -- reforms that</p> <p>18 have happened that have had a significant impact are</p> <p>19 those where there is both a time limit but also</p> <p>20 a process for considering the person's situation before</p> <p>21 they go into detention. So, for example, the family</p> <p>22 returns process requires a number of meetings before</p> <p>23 detention can be authorised and for information to be</p> <p>24 obtained from, for example, the person's GP or bodies</p> <p>25 that have provided therapy or social workers so that</p> <p style="text-align: center;">Page 92</p>

<p>1 there is information which can be considered, which, of</p> <p>2 course, the gatekeeper can't at the moment.</p> <p>3 Q. Medical Justice makes some recommendations for reform of</p> <p>4 the Adults at Risk policy, and the recommendation or</p> <p>5 suggestion is that there is an urgent need to return to</p> <p>6 a category-based approach, as you have talked about</p> <p>7 somewhat in your evidence, to the identification of</p> <p>8 vulnerabilities, as indeed Mr Shaw recommended in his</p> <p>9 first report, where vulnerable people are treated as</p> <p>10 unsuitable, save in very exceptional circumstances. Is</p> <p>11 that right?</p> <p>12 A. Absolutely, yes.</p> <p>13 Q. Another suggestion is abolishing the requirement for</p> <p>14 specific evidence of risk of harm?</p> <p>15 A. Yes. I think that goes with returning to</p> <p>16 a category-based approach.</p> <p>17 Q. So the two go in tandem?</p> <p>18 A. Absolutely.</p> <p>19 Q. You say that there should be an effective screening of</p> <p>20 vulnerabilities, disabilities, trauma and mental health</p> <p>21 problems before the person is detained, and that, again,</p> <p>22 goes back to the gatekeeper role. In your view, should</p> <p>23 the gatekeeper -- the detention gatekeeper role be</p> <p>24 abolished?</p> <p>25 A. The gatekeeper isn't independent in any way and doesn't</p> <p style="text-align: center;">Page 93</p>	<p>1 Q. So a proper mental and physical examination?</p> <p>2 A. Exactly, focused and aimed at establishing some level of</p> <p>3 trust and eliciting disclosure of indicators that the</p> <p>4 person is at risk of harm.</p> <p>5 Q. Medical Justice is of the view that rule 35 needs</p> <p>6 complete reform; is that right?</p> <p>7 A. Absolutely.</p> <p>8 Q. Part of that would be that rule 35 reports weren't</p> <p>9 routinely rejected and not leading to a release from</p> <p>10 detention; is that right?</p> <p>11 A. Exactly.</p> <p>12 Q. There is also an urgent need to address the disconnect</p> <p>13 between the rule 35 safeguard and the Adults at Risk</p> <p>14 policy and that's what the category-based approach would</p> <p>15 be designed to achieve, is it?</p> <p>16 A. Yes, and also rule 35 would need to cover all the</p> <p>17 categories.</p> <p>18 Q. Yes, which it doesn't at the moment?</p> <p>19 A. Exactly.</p> <p>20 Q. There are various suggestions about improving training</p> <p>21 and training has been a consistent theme.</p> <p>22 Medical Justice would like to see better training for</p> <p>23 all healthcare staff in the delivery of trauma-informed</p> <p>24 clinical care and aimed at better identification of</p> <p>25 PTSD. You would agree with that?</p> <p style="text-align: center;">Page 95</p>
<p>1 have any access to independent information, so that's</p> <p>2 why they're ineffective. I think a more independent</p> <p>3 setup would be more likely to be effective.</p> <p>4 Q. A suggestion is made that that could be a detention</p> <p>5 review panel with a procedure for proactive enquiry, so</p> <p>6 that the panel is satisfied that there are no legal or</p> <p>7 practical barriers to removal and all relevant</p> <p>8 up-to-date evidence has been obtained and considered by</p> <p>9 the Home Office about the person's health and any other</p> <p>10 vulnerability?</p> <p>11 A. Exactly. Quite often, when someone is in detention,</p> <p>12 a few months down the road it turns out that there was</p> <p>13 evidence that should have been available right from the</p> <p>14 beginning that they could not be removed anyway. For</p> <p>15 example, the -- for example, D1914. That information</p> <p>16 could have been made available right from the outset and</p> <p>17 he should never have been detained.</p> <p>18 Q. You say a pre-detention screening must be coupled with</p> <p>19 an effective clinical screening process upon a person's</p> <p>20 detention. So where that process hasn't happened prior</p> <p>21 to detention and someone been screened out, there must</p> <p>22 be more than a tick-box exercise once they have been</p> <p>23 received into detention; is that right?</p> <p>24 A. Exactly. So that's essentially rule 34 being properly</p> <p>25 implemented.</p> <p style="text-align: center;">Page 94</p>	<p>1 A. I think that's really important. But I also think that</p> <p>2 training in itself is not going to solve that problem</p> <p>3 because training is going to struggle to get at that</p> <p>4 toxic culture that exists within detention and the</p> <p>5 culture of disbelief that's proven quite enduring.</p> <p>6 Q. Further better training also on the Adults at Risk</p> <p>7 policy and rule 35, we heard consistent reports of</p> <p>8 a lack of, or a lack of adequate, training in those two</p> <p>9 areas that remain the case today; is that right?</p> <p>10 A. Yes.</p> <p>11 Q. There should be a focus on ongoing review under rule 35,</p> <p>12 shouldn't there, not just a one opportunity, either at</p> <p>13 the beginning of detention or when one rule 35</p> <p>14 assessment is carried out. Dr Hard notes in his report</p> <p>15 there seems to be a complete absence of any follow-up to</p> <p>16 review the ongoing detention and its impact on someone;</p> <p>17 is that right?</p> <p>18 A. Exactly. I think that's really important. But I think</p> <p>19 that review needs to be directed at identifying</p> <p>20 indicators that the person is at risk of deteriorating</p> <p>21 and not waiting for actual deterioration to occur.</p> <p>22 Q. Yes, indeed. In Medical Justice's view, as both you and</p> <p>23 Dr Bingham have discussed, IRCs are not really a place</p> <p>24 to treat mental illness, are they?</p> <p>25 A. (Witness nods).</p> <p style="text-align: center;">Page 96</p>

<p>1 Q. The suggestion is healthcare should have</p> <p>2 a responsibility to raise concerns about the suitability</p> <p>3 of the person for continued detention as soon as mental</p> <p>4 illness is identified; is that right?</p> <p>5 A. Yes, exactly.</p> <p>6 Q. There needs to be better training, as we have touched</p> <p>7 upon, in mental capacity as well?</p> <p>8 A. Yes, absolutely.</p> <p>9 Q. Part of the issues in relation to mental capacity you</p> <p>10 mentioned were the lack of a role for independent</p> <p>11 advocacy services. You would like to see the</p> <p>12 introduction of those in relation to the assessment of</p> <p>13 mental capacity?</p> <p>14 A. Yes, and I think it is important that they would come in</p> <p>15 at quite a low level, so when there's suspicion of</p> <p>16 a lack of mental capacity or a concern about it.</p> <p>17 Q. You would like to see the ACDT process linked with the</p> <p>18 Adults at Risk policy and rule 35, such that, as we have</p> <p>19 seen, does not currently happen and didn't happen in</p> <p>20 2017. An ACDT would trigger the operation of rules</p> <p>21 35(1) or rule 35(2) in the appropriate circumstance and</p> <p>22 reports made, or an alternative means for the</p> <p>23 Home Office reviewing detention?</p> <p>24 A. Yes, exactly.</p> <p>25 Q. In relation to use of force, the suggestion is that the</p> <p style="text-align: center;">Page 97</p>	<p>1 Panorama and in multiple other situations before, in</p> <p>2 dealing with Mubenga's case, who died while being forced</p> <p>3 onto a plane, in the undercover filming at Oakington and</p> <p>4 at Yarl's Wood and, as Stephen Shaw said after</p> <p>5 Oakington, being a detention custody officer is not</p> <p>6 a job just like any other. I think it does have an</p> <p>7 impact on people working in that environment to see the</p> <p>8 sort of disturbed behaviour, to see people routinely</p> <p>9 being subjected to the use of force, and of course</p> <p>10 detained people being people that their job is to manage</p> <p>11 out of the country, so the message is that they don't</p> <p>12 belong here. I think it is quite easy to slip into that</p> <p>13 these are people who don't have the same kind of worth.</p> <p>14 I'm not in any way an expert in organisational culture</p> <p>15 but I think it is unsurprising that this is an issue</p> <p>16 that has come up again and again.</p> <p>17 Q. In relation to segregation, there are various proposals</p> <p>18 for change: that it shouldn't be used to manage or</p> <p>19 contain people who are suffering from serious mental</p> <p>20 illness or at risk of self-harming or suicide other than</p> <p>21 in the most exceptional circumstances where there is an</p> <p>22 immediate threat to that person's life; is that right?</p> <p>23 A. Yes, absolutely.</p> <p>24 Q. You would like to see any transfer to segregation for</p> <p>25 clinical reasons triggering a rule 35 report?</p> <p style="text-align: center;">Page 99</p>
<p>1 prison-based model of control and restraint is</p> <p>2 inappropriate for a detention centre. What would you</p> <p>3 like to see in its place?</p> <p>4 A. A lot more focus on de-escalation and therapeutic</p> <p>5 interventions. I think, at the moment, measures that</p> <p>6 are likely to be perceived by the detainee as punitive</p> <p>7 are the first line of response to disturbed behaviour,</p> <p>8 which is often not identified as caused by mental</p> <p>9 illness, and so you get increasingly unwell detained</p> <p>10 people behaving in ways that are difficult to manage,</p> <p>11 and then you get more and more use of force, and of</p> <p>12 course, that's also distressing for everyone else there</p> <p>13 who witnesses it. It creates a sort of climate of fear</p> <p>14 and the situations in which the IMB, in 2020, said that</p> <p>15 the entire detained population was being subjected to</p> <p>16 inhumane treatment. And I think that's sort of</p> <p>17 inevitable when you get all these factors coming</p> <p>18 together in the way that Dr Bingham described as</p> <p>19 "a perfect storm". That's when the situation is utterly</p> <p>20 terrifying, probably for everyone involved. It fuels</p> <p>21 decentralisation, it fuels a normalisation of the use of</p> <p>22 force and of very distressed behaviour.</p> <p>23 Q. And it exposes detainees to a risk of mistreatment?</p> <p>24 A. Exactly. I guess the other thing that comes into it</p> <p>25 there is the racism that's been revealed both in</p> <p style="text-align: center;">Page 98</p>	<p>1 A. Yes.</p> <p>2 Q. And indeed, thereafter release from detention unless</p> <p>3 someone's transferred to an inpatient psychiatric</p> <p>4 setting?</p> <p>5 A. Yes.</p> <p>6 Q. Because, of course, the importance isn't just the</p> <p>7 writing of the report but what happens with it?</p> <p>8 A. Yes, exactly. The reports need to be properly</p> <p>9 effective. Even rule 35(1) reports don't always lead to</p> <p>10 release.</p> <p>11 Q. Healthcare staff shouldn't be approving or authorising</p> <p>12 the use of segregation, in your view?</p> <p>13 A. Absolutely.</p> <p>14 Q. Their remit should be confined to raising</p> <p>15 contraindications or concerns and triggering a review of</p> <p>16 continued detention?</p> <p>17 A. That's right.</p> <p>18 Q. In your view, there should be a review of the use of</p> <p>19 E wing in Brook House as I think your view is that it is</p> <p>20 being used informally, so not under the safeguards of</p> <p>21 the rules -- rules 40 and 42, as segregation?</p> <p>22 A. Exactly.</p> <p>23 Q. And that can be very damaging to a detainee's,</p> <p>24 particularly mental, health?</p> <p>25 A. Absolutely.</p> <p style="text-align: center;">Page 100</p>

<p>1 Q. In relation to monitoring and oversight, we have talked</p> <p>2 a little about gaps in oversight and monitoring by the</p> <p>3 Home Office. What would you like to see them do in</p> <p>4 order to strengthen their monitoring and oversight of</p> <p>5 the safeguards in relation to vulnerable detainees?</p> <p>6 A. I think there needs to be proper monitoring and regular</p> <p>7 monitoring of not only the procedural aspects of it, but</p> <p>8 also the content and the effectiveness of it. But the</p> <p>9 other thing that needs to happen is that action actually</p> <p>10 needs to be taken. It was known that there was no</p> <p>11 rule 35(2) reports and very few rule 35(1) reports and</p> <p>12 somehow that doesn't seem to have rung alarm bells</p> <p>13 either within the centre or at the Home Office. So</p> <p>14 monitoring is really important, but it's not worth very</p> <p>15 much unless effective action is taken as a result.</p> <p>16 Q. In your view, if these proposals for change were</p> <p>17 accepted and were actually to occur, is that likely, in</p> <p>18 your view, to lead to less risk of mistreatment of</p> <p>19 detained persons in detention?</p> <p>20 A. I would hope so, but the reason I'm really cautious is</p> <p>21 because there have been so many recommendations and</p> <p>22 there are policies in place that on paper sound quite</p> <p>23 good if they were properly implemented: that's why we</p> <p>24 think, unless the power to detain is seriously</p> <p>25 curtailed, that it is inevitable that we see these sorts</p> <p style="text-align: center;">Page 101</p>	<p>1 some of the contents of that statement and I am going to</p> <p>2 show you some footage this afternoon and ask you some</p> <p>3 questions about it?</p> <p>4 A. Okay.</p> <p>5 Q. I may not ask you about every single line of that</p> <p>6 statement, because I am going to ask that the statement</p> <p>7 is adduced in full, which means it stands as your</p> <p>8 evidence to the inquiry. I'm just going to ask you some</p> <p>9 questions about your background as a nurse. You say in</p> <p>10 your statement, at paragraphs 1 and 2, that you have</p> <p>11 38 years' experience as a general nurse; is that right?</p> <p>12 A. Yes, that's right.</p> <p>13 Q. Your experience of nursing in a custodial setting began</p> <p>14 when you worked for the Prison Service between 1994 and</p> <p>15 1999; is that right?</p> <p>16 A. Yes, that's right.</p> <p>17 Q. And again for the Prison Service between 2001 and 2004;</p> <p>18 is that right?</p> <p>19 A. Yes, that's right.</p> <p>20 Q. You then worked at Tinsley House in 2004 and left in</p> <p>21 2006 to work as an agency nurse, often working in local</p> <p>22 hospitals, and between 2008 and 2012, you also worked</p> <p>23 for the Police Service attending people in custody who</p> <p>24 required medical attention; is that right?</p> <p>25 A. That's right.</p> <p style="text-align: center;">Page 103</p>
<p>1 of abuses.</p> <p>2 MS SIMCOCK: Thank you. Chair, I have no further questions</p> <p>3 for this witness. Do you have any questions at all?</p> <p>4 THE CHAIR: I don't. You have asked all of my questions</p> <p>5 that I had, Ms Simcock. Thank you very much.</p> <p>6 MS SIMCOCK: So a slightly early lunch break. Should</p> <p>7 I suggest an hour, in any event, and we will come back</p> <p>8 at 1.45 pm?</p> <p>9 THE CHAIR: 1.45 pm, thank you. Thank you for much for</p> <p>10 coming to give your evidence today. I know it is not an</p> <p>11 easy experience, but it has been very important to hear</p> <p>12 from you.</p> <p>13 A. Thank you.</p> <p>14 (The witness withdrew)</p> <p>15 (12.45 pm)</p> <p>16 (The short adjournment)</p> <p>17 (1.45 pm)</p> <p>18 MS SIMCOCK: The witness this afternoon is Joanne Buss.</p> <p>19 Thank you.</p> <p>20 MS JOANNE MARIA BUSS (affirmed)</p> <p>21 Examination by MS SIMCOCK</p> <p>22 MS SIMCOCK: Can you give your full name, please?</p> <p>23 A. Joanne Maria Buss.</p> <p>24 Q. Ms Buss, you have made a statement to the inquiry which</p> <p>25 we find at <INN000025>. I am going to ask you about</p> <p style="text-align: center;">Page 102</p>	<p>1 Q. You say that, in 2010, you returned to Brook House and</p> <p>2 Tinsley House, initially working at Brook House, but</p> <p>3 soon after, in around 2010 or 2011, you moved to</p> <p>4 Tinsley House, where you remained as a senior nurse</p> <p>5 until 2017?</p> <p>6 A. (Witness nods).</p> <p>7 Q. Is all that right?</p> <p>8 A. That's right, yes.</p> <p>9 Q. In February or March 2017, you say you moved to</p> <p>10 Brook House, because we have heard that Tinsley House</p> <p>11 was undergoing refurbishment, so all the staff moved</p> <p>12 across; is that right?</p> <p>13 A. Yes.</p> <p>14 Q. You were promoted to the position of clinical lead for</p> <p>15 Tinsley House in May 2017, whilst still working at</p> <p>16 Brook House and, from April 2017, you say you didn't do</p> <p>17 much work with patients at Brook House because you were</p> <p>18 heavily involved in the preparations for the move back</p> <p>19 to Tinsley House?</p> <p>20 A. Be from May.</p> <p>21 Q. Thank you. You remained at Tinsley House until your</p> <p>22 suspension on 5 September 2017. You talk about your</p> <p>23 shifts at Brook House and you say you were there from</p> <p>24 7.00 in the morning to 7.30 in the evening three days</p> <p>25 per week, and when you moved back to Tinsley House</p> <p style="text-align: center;">Page 104</p>

<p>1 in May 2017, your shifts became 8.00 o'clock in the</p> <p>2 morning until 4.40 five days a week; is that right?</p> <p>3 A. 4.30.</p> <p>4 Q. 4.30. I'm sorry, that's my mistake. I want to ask you</p> <p>5 something about the standards that apply to being</p> <p>6 a Registered Nurse. Nursing is a profession regulated</p> <p>7 by the Nursing & Midwifery Council; is that right?</p> <p>8 A. That's right.</p> <p>9 Q. Certain standards apply to being a nurse that you will</p> <p>10 obviously have been familiar with that apply</p> <p>11 irrespective of any additional rules that you were</p> <p>12 required to follow by your employer; is that right?</p> <p>13 A. Yes, that's right.</p> <p>14 Q. I just want to go through very briefly some of them and</p> <p>15 see if you agree. Those included putting the needs of</p> <p>16 your patients first and ensuring their rights were</p> <p>17 upheld, including challenging any discriminatory</p> <p>18 behaviour; would you agree?</p> <p>19 A. Yes.</p> <p>20 Q. Keeping accurate records and providing honest and</p> <p>21 accurate feedback to colleagues; would you agree with</p> <p>22 that?</p> <p>23 A. Yes.</p> <p>24 Q. In terms of the safety of patients, you were obliged to</p> <p>25 ensure you accurately assessed signs of worsening</p> <p style="text-align: right;">Page 105</p>	<p>1 Q. The mornings tended to be a walk-in clinic and the</p> <p>2 afternoons were when longer appointments took place?</p> <p>3 A. Yes.</p> <p>4 Q. In addition, a member of the healthcare team had to</p> <p>5 attend every incident, such as intoxication by drugs,</p> <p>6 use of force or acts of self-harm; is that right?</p> <p>7 A. That's right.</p> <p>8 Q. You decided, amongst yourselves, who would respond.</p> <p>9 A call would go out for healthcare to attend over the</p> <p>10 radio, and whoever was available --</p> <p>11 A. Would go.</p> <p>12 Q. -- one or two members of the team would go?</p> <p>13 A. Mmm.</p> <p>14 Q. There was also a role in screening new arrivals into</p> <p>15 Brook House in terms of reception screening; is that</p> <p>16 right?</p> <p>17 A. That's right.</p> <p>18 Q. Did you ever undertake that role?</p> <p>19 A. We all did, yeah.</p> <p>20 Q. And that often led to the identification of</p> <p>21 vulnerabilities, such as mental health issues or risk of</p> <p>22 self-harm requiring an ACDT; is that right?</p> <p>23 A. That's right.</p> <p>24 Q. You would have been familiar with the system under the</p> <p>25 ACDT to manage self-harm and risk of suicide?</p> <p style="text-align: right;">Page 107</p>
<p>1 physical and mental health in a person receiving care</p> <p>2 and to make timely referrals; would you agree with that?</p> <p>3 A. Yes.</p> <p>4 Q. You were required to act without delay if you believed</p> <p>5 there was a risk to a patient?</p> <p>6 A. Yes.</p> <p>7 Q. And to raise concerns immediately if you believed</p> <p>8 a person was vulnerable or at risk and needed extra</p> <p>9 support or protection; is that right?</p> <p>10 A. Yes.</p> <p>11 Q. Those applied just as much in detention as they would in</p> <p>12 any other setting?</p> <p>13 A. Yes, that's right.</p> <p>14 Q. Just dealing with what roles and responsibilities you</p> <p>15 had as a nurse in Brook House, you say that the team</p> <p>16 comprised qualified nurses and healthcare assistants,</p> <p>17 and there were mental health nurses as well as general</p> <p>18 nurses?</p> <p>19 A. That's right.</p> <p>20 Q. You would administer medication that had been provided</p> <p>21 by -- or prescribed by the GP; is that right?</p> <p>22 A. (Witness nods).</p> <p>23 Q. And you would triage patients who attended healthcare,</p> <p>24 making referrals to a doctor where necessary?</p> <p>25 A. That's right.</p> <p style="text-align: right;">Page 106</p>	<p>1 A. Yes.</p> <p>2 Q. You say the tasks -- these tasks were time consuming and</p> <p>3 there was an unrealistic expectation of what the team</p> <p>4 could deliver. Are you talking there about</p> <p>5 understaffing?</p> <p>6 A. Understaffing, the volume of people that could come in</p> <p>7 on any one day, the length of the assessment and, if you</p> <p>8 had to do referrals, you all had to make doctors</p> <p>9 appointments for the next day. Yeah, it was just not --</p> <p>10 not easy.</p> <p>11 Q. That's specifically in relation to reception screening?</p> <p>12 A. That's reception screening.</p> <p>13 Q. I want to deal then with the NMC proceedings that were</p> <p>14 taken against you as a result of the incident that was</p> <p>15 shown in Panorama. I just want to look at the result of</p> <p>16 those hearings. So there was a hearing -- following</p> <p>17 a hearing on 23 February 2021, so quite recently.</p> <p>18 A. Okay.</p> <p>19 Q. The NMC struck you off the nursing register as a result</p> <p>20 of your actions on 25 April 2017, and what they referred</p> <p>21 to as your failures to safeguard D1527; is that right?</p> <p>22 A. I was struck off, yes.</p> <p>23 Q. The charges against you were that you, as a Registered</p> <p>24 Nurse, on 25 April 2017 at Brook House Immigration</p> <p>25 Removal Centre, one:</p> <p style="text-align: right;">Page 108</p>

27 (Pages 105 to 108)

<p>1 "Failed to take steps to safeguard person A [who we 2 know is D1527; that was how the 3 Nursing & Midwifery Council referred to him] in that you 4 did not intervene when person A was inappropriately 5 restrained by detention officers." 6 That was the first charge. The second was: 7 "Made an inappropriate comment in relation to person 8 A, referring to him as 'an arse'. 9 The third: 10 "Failed to undertake and record observations on 11 person A following the use of force and restraint on 12 person A by detention officers." 13 Fourth: 14 "Made an inaccurate entry on person A's medical 15 records omitting the use of force and restraint by 16 detention centres on person A." 17 Fifthly: 18 "Your actions in relation to 4 above [that's the 19 entry in the notes] were dishonest in that you 20 deliberately sought to conceal that force and restraint 21 had been used by detention officers against person A." 22 In conclusion, they said, in light of the above, 23 your fitness to practise was impaired by reason of your 24 misconduct. Are those familiar to you as the charges 25 against you by the NMC?</p> <p style="text-align: center;">Page 109</p>	<p>1 Q. Thirdly, you did not see DCO Paschali's hands around 2 D1527's neck and, had you done so, you would have 3 definitely stopped to intervene; is that right? 4 A. Of course I would. 5 Q. Your handwritten notes were brief because you were 6 suffering pain in your hand, not because you were trying 7 to cover up the facts; is that right? 8 A. That's right. 9 Q. You recorded the use of force incident by DCO Paschali, 10 DCO Tulley and others in your medical records, as you 11 were required to do, and that you recorded the events 12 and D1527's injuries appropriately, being to update the 13 ACDT record, update the SystmOne record -- that's the 14 medical notes -- and to complete a form F213; is that 15 right? 16 A. That's right. I asked somebody else to complete the 213 17 for me. 18 Q. Absolutely. We will come to the detail of that in 19 a moment. But your position is essentially that you 20 completed the required records? 21 A. I did. 22 Q. The level of detail recorded in your notes was not 23 unusually brief and should not be seen as evidence of 24 collusion or a coverup. Essentially, you say the 25 records you made were adequate; is that right?</p> <p style="text-align: center;">Page 111</p>
<p>1 A. Yes. 2 Q. On 16 February 2021, you emailed the NMC and made a full 3 admission on all charges, and we find that at 4 <INN000026>, which is the exhibit to your witness 5 statement to the inquiry. Do you remember that? 6 A. That email? 7 Q. Yes. 8 A. Yes. 9 Q. In your witness statement to the inquiry, you now 10 confirm that your position has changed, and you 11 effectively deny all of those charges, except for the 12 one at charge 2. 13 A. I do. 14 Q. Which is the comment. 15 A. Yes. 16 Q. Can I just summarise, then, what your position is now, 17 in relation to those charges. In summary, what you say 18 is, you now have no memory of the incident, but, based 19 upon your review of the video footage, you believe 20 you've been treated unfairly by G4S and the NMC. You 21 accept and apologise for calling D1527 an "arse", but 22 say that the door to his room was shut and there was no 23 possibility that he could have heard the comment; is 24 that right? 25 A. That's right.</p> <p style="text-align: center;">Page 110</p>	<p>1 A. Yes. 2 Q. You say the records were correct and appropriate, having 3 regard to the circumstances you witnessed? 4 A. Yes. 5 Q. So that accurately summarises what your present position 6 is; is that right? 7 A. That does. 8 Q. Before we come, then, to the specifics of the incident 9 on 25 April 2017, I just want to ask you a few questions 10 about your memory of events. In your statement at 11 paragraph 8, you refer to a distressing incident you 12 witnessed in the Prison Service in 2001. I'm not going 13 to ask you about that in any detail. But you say that 14 it changed the way you approached work generally. At 15 paragraph 10, you say that you found the only way to 16 cope with working at Tinsley House and Brook House was 17 to completely leave the events of the working day behind 18 you when you left work for the day; is that right? 19 A. That's right. 20 Q. Do you think that made you somewhat detached from your 21 work at the time? 22 A. Not when I was working, no, but when I left work, 23 everything stayed at work. It didn't come home with me. 24 Q. I see. Do you think that you became at all desensitised 25 to the things that you saw at Brook House, such as</p> <p style="text-align: center;">Page 112</p>

<p>1 incidents of self-harm?</p> <p>2 A. No. No.</p> <p>3 Q. Do you think that your approach to work in that way</p> <p>4 compromised your ability to do your job?</p> <p>5 A. No.</p> <p>6 Q. Do you think that you recognised and responded</p> <p>7 appropriately, then, to vulnerable detainees</p> <p>8 experiencing mental ill-health?</p> <p>9 A. As far as I'm aware, yes.</p> <p>10 Q. You say, when you were interviewed in September 2017 by</p> <p>11 G4S -- it's been suggested that you were deliberately</p> <p>12 vague, and that's not the case. You simply genuinely</p> <p>13 couldn't remember very much about the events of that</p> <p>14 day?</p> <p>15 A. That's right.</p> <p>16 Q. In relation to -- can we have it up on screen,</p> <p>17 <TRN0000100> at page 8, please. Ms Buss, this is, as</p> <p>18 that first page said, a transcript of a conversation</p> <p>19 that you had with DCO Callum Tulley on 3 May 2017, so</p> <p>20 some days after the incident on 25 April. Here you</p> <p>21 discuss D1527 and the events on 25 April with</p> <p>22 Callum Tulley and another officer in the staff room. If</p> <p>23 we look at line 210, the line numbers are on the</p> <p>24 left-hand side, you say:</p> <p>25 "Never seen anything like it. You know the</p> <p style="text-align: center;">Page 113</p>	<p>1 A. Exactly, yes.</p> <p>2 Q. Just while we are on this transcript, given we have got</p> <p>3 it, was "a massive hissy hit on the floor" an</p> <p>4 appropriate way to describe D1527's condition and</p> <p>5 presentation on 25 April?</p> <p>6 A. No, probably not.</p> <p>7 Q. He was in an acute mental health crisis, wasn't he?</p> <p>8 A. He was upset.</p> <p>9 Q. Does "upset" accurately describe how he presented on</p> <p>10 that day?</p> <p>11 A. He was under the care of the mental health nurses, who</p> <p>12 kept him under their care. I had no knowledge of this</p> <p>13 man at all.</p> <p>14 Q. But he was more than upset, wasn't he?</p> <p>15 A. He was angry.</p> <p>16 Q. He was angry and upset?</p> <p>17 A. From what I can recall.</p> <p>18 Q. Wasn't he very unwell?</p> <p>19 A. I don't know. He was under the care of the mental</p> <p>20 health nurses, the mental health team, and there was an</p> <p>21 RMN with him.</p> <p>22 Q. He had attempted suicide?</p> <p>23 A. He'd attempted to self-strangulate, I believe.</p> <p>24 Q. And he'd attempted to self-harm prior to his move to</p> <p>25 E wing. He was very distressed, wasn't he?</p> <p style="text-align: center;">Page 115</p>
<p>1 observation door on E wing? His feet were going up --</p> <p>2 up the door, fucks sake."</p> <p>3 Callum replies, and you continue, and you say:</p> <p>4 "Strangling, yeah, but a phone battery at the --</p> <p>5 those flat -- a Nokia battery that he wanted to swallow.</p> <p>6 But he self-strangled, then he went up the door, then</p> <p>7 he had a massive hissy fit on the floor. And</p> <p>8 apparently, a couple of hours later, he was as right as</p> <p>9 rain."</p> <p>10 Would you agree that at least on 3 May you</p> <p>11 remembered this incident because you were talking about</p> <p>12 it then?</p> <p>13 A. I would have remembered some of it because it was quite</p> <p>14 fresh.</p> <p>15 Q. Yes.</p> <p>16 A. But it wouldn't have stayed in my memory.</p> <p>17 Q. You describe that you had never seen anything like it.</p> <p>18 That suggests, doesn't it, that the event was very</p> <p>19 memorable to you?</p> <p>20 A. I don't know. I wouldn't know.</p> <p>21 Q. But your position today -- we are obviously some five</p> <p>22 years on, almost -- speaking now, is that you didn't</p> <p>23 remember very much about the events on 25 April at all,</p> <p>24 and you are essentially going on your viewing of</p> <p>25 the footage; is that right?</p> <p style="text-align: center;">Page 114</p>	<p>1 A. He was distressed.</p> <p>2 Q. Were you attempting there to suggest that his actions</p> <p>3 were a deliberate manipulation rather than due to mental</p> <p>4 ill-health?</p> <p>5 A. Not at all.</p> <p>6 Q. That he was attention seeking?</p> <p>7 A. Not at all.</p> <p>8 Q. Having a tantrum like a child?</p> <p>9 A. Not at all.</p> <p>10 Q. "Hissy fit on floor"?</p> <p>11 A. Not at all.</p> <p>12 Q. Was the comment about him being right as rain in</p> <p>13 a couple of hours meant to convey that it had been</p> <p>14 attention-seeking behaviour deliberately and not as</p> <p>15 a result of underlying mental ill-health?</p> <p>16 A. No, I suspect from -- just thinking about it, is that he</p> <p>17 was okay afterwards.</p> <p>18 Q. Thank you. That can be taken down. If we look, then,</p> <p>19 at the background to the incident on 25 April, D1527 had</p> <p>20 been removed to E wing due to his self-harming</p> <p>21 behaviour, hadn't he? Do you remember that?</p> <p>22 A. Yes, he's been moved.</p> <p>23 Q. Was that not just with D1527, but was that a common</p> <p>24 occurrence, that detainees who self-harmed were often</p> <p>25 moved to E wing to be observed?</p> <p style="text-align: center;">Page 116</p>

1 **A. From what I recall.**
 2 Q. And sometimes force was used in order to effect their
 3 removal from their wing to E wing. Do you remember that
 4 happening at the time in 2017?
 5 **A. Not that I'm aware of, that I can recall.**
 6 Q. Detainees were managed on E wing on ACDT sometimes on
 7 constant watch. Do you remember that?
 8 **A. Yes.**
 9 Q. Which indicated, if they were on constant watch, a high
 10 risk of suicide. Would you agree?
 11 **A. Yes.**
 12 Q. D1527 was on an ACDT and he was on constant supervision
 13 or constant watch at the time, wasn't he?
 14 **A. Yes, I think so. Yes.**
 15 Q. That indicated, as you have just agreed, a high risk of
 16 suicide in his case; is that right?
 17 **A. Yeah, yeah.**
 18 Q. Force was used to move him to E wing and, on 24 April,
 19 he then attempted suicide, or at least a serious act of
 20 self-harm, by tying a ligature around his neck in the
 21 form of a bed sheet. Were you aware of that?
 22 **A. No.**
 23 Q. A use of force form was filled in, and the healthcare
 24 section was filled in by Melissa Morley. I don't think
 25 you were involved at this stage, but you're now aware

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1 that that's the case; is that right?
 2 **A. That's right, yes.**
 3 Q. Do you think you would have known about that incident
 4 when you attended the incident on 25 April?
 5 **A. No.**
 6 Q. Why not?
 7 **A. If he was under the care of the RMNs, he would have been**
 8 **in their care and not always information passed. There**
 9 **was 400 detainees there, so you would never know every**
 10 **detainee.**
 11 Q. I see.
 12 **A. You would only know if it was handed over to you.**
 13 Q. Before we come to 25 April specifically, just generally
 14 on use of force, use of force could be planned or
 15 unplanned; is that right?
 16 **A. That's right.**
 17 Q. In a planned use of force, healthcare would have input
 18 beforehand?
 19 **A. Yes.**
 20 Q. Their role was to raise concerns or contraindications --
 21 that's reasons not to use force -- in the appropriate
 22 circumstances; is that correct?
 23 **A. That's correct.**
 24 Q. Were you aware at the time that the use of force on
 25 someone who was mentally unwell could worsen their

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1 symptoms, such as of PTSD, for example?
 2 **A. No.**
 3 Q. It could potentially lead to their non-engagement with
 4 healthcare staff. Were you aware of that at the time?
 5 **A. Yes.**
 6 Q. Especially in the context of self-harm; is that right?
 7 **A. It could be. But quite often they would engage with**
 8 **healthcare.**
 9 Q. Were you, at the time, familiar with the NICE guidance
 10 and standards in relation to the management of
 11 self-harm?
 12 **A. I might have been. I don't know now.**
 13 Q. Do you think you ought to have been, given the
 14 prevalence of self-harm in Brook House at the time?
 15 **A. Probably, at the time, I used them, but now I don't**
 16 **know.**
 17 Q. It's some time ago.
 18 **A. I don't have any ...**
 19 Q. In relation to the safeguarding role that healthcare had
 20 in relation to planned use of force, do you think you
 21 had a good understanding of that role at the time in
 22 2017?
 23 **A. From what I recall, yes.**
 24 Q. Would that involve reviewing a patient's medical records
 25 before attending the briefing about a planned use of

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1 force?
 2 **A. For a planned use of force, yes.**
 3 Q. Would it involve an assessment of the detainee in
 4 person?
 5 **A. Not necessarily.**
 6 Q. Would it involve carrying out a risk assessment in
 7 relation to the use of force on them?
 8 **A. I don't know.**
 9 Q. Did you ever carry out this role of attending a briefing
 10 and then, subsequently, in the actual planned use of
 11 force itself in 2017? Was it something you did?
 12 **A. Maybe before/up to 2017.**
 13 Q. Did you ever advise that force should not be used on
 14 a detainee due to their mental ill-health or
 15 vulnerabilities?
 16 **A. Several times.**
 17 Q. What happened in those times? Was there still a use of
 18 force carried out or not?
 19 **A. I don't know. But there have been times when use of**
 20 **force has not been carried out.**
 21 Q. Did you ever advise that force should not be used on
 22 a detainee who had self-harmed?
 23 **A. I would think so.**
 24 Q. But you don't know?
 25 **A. You're asking me five, six years, seven years ago,**

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30 (Pages 117 to 120)

<p>1 I don't know.</p> <p>2 Q. You can't remember?</p> <p>3 A. No.</p> <p>4 Q. I'm sorry, I have just been told that people on the live</p> <p>5 feed are struggling to hear you. Would you mind just</p> <p>6 ever so slightly keeping your voice slightly louder?</p> <p>7 A. Okay.</p> <p>8 Q. You say in your witness statement, at paragraph 47, that</p> <p>9 use of force to prevent self-harm is not uncommon. Were</p> <p>10 those mainly unplanned uses of force in direct response</p> <p>11 to an incident?</p> <p>12 A. I would think so.</p> <p>13 Q. Let's come then to the incident on 25 April. At</p> <p>14 paragraph 19 of your statement, you have essentially</p> <p>15 summarised the key footage and your observations on it.</p> <p>16 I just now want to play some of it -- not all of it, but</p> <p>17 some of the footage -- in relation to the incident. If</p> <p>18 we could start, please, with KENCOV1007 V2017042500020.</p> <p>19 If we can start at the counter time of 06:56, please,</p> <p>20 and play until 07:09, if that's possible, or</p> <p>21 thereabouts.</p> <p>22 (Video played)</p> <p>23 MS SIMCOCK: Pause there.</p> <p>24 You deal with this time in your witness statement</p> <p>25 where Steve Loughton says "The use of force, flipping</p> <p style="text-align: center;">Page 121</p>	<p>1 it?</p> <p>2 A. It was inappropriate.</p> <p>3 Q. Within earshot of D1527?</p> <p>4 A. Yes.</p> <p>5 Q. We will come to it in a moment, but we know you accept</p> <p>6 that you later referred to D1527 as an "arse". Did</p> <p>7 DCM Loughton's view that he was a "cock" also represent</p> <p>8 your view?</p> <p>9 A. Maybe. I can't remember. I wouldn't know.</p> <p>10 Q. It's similar language, isn't it?</p> <p>11 A. It is similar.</p> <p>12 Q. If we can carry on playing, then, please, from where we</p> <p>13 are to 07:29.</p> <p>14 (Video played)</p> <p>15 MS SIMCOCK: So this is a conversation in the presence of</p> <p>16 D1527 between Nathan Ring -- in your presence, which you</p> <p>17 respond to, where Nathan Ring says:</p> <p>18 "Going all night, isn't he?"</p> <p>19 You reply, "Yeah". Nathan Ring says:</p> <p>20 "Going all night. Duracell bunny, isn't he?</p> <p>21 Swallowing batteries."</p> <p>22 And then "You're full of it" and then "Burn his</p> <p>23 tongue". In your witness statement, you said that the</p> <p>24 "Yeah" we hear on the footage doesn't mean that you</p> <p>25 agreed with the joke that Mr Ring was making and that</p> <p style="text-align: center;">Page 123</p>
<p>1 paperwork", and saying -- he makes a reference to the</p> <p>2 use of force paperwork, but we can hear on the footage</p> <p>3 that he also refers to D1527 as a "cock" too, can't we?</p> <p>4 A. Yes.</p> <p>5 Q. That's clear from the footage. Why is that not included</p> <p>6 in your witness statement?</p> <p>7 A. I don't know.</p> <p>8 Q. It's picked up by DCO Tulley's undercover camera whilst</p> <p>9 he's sitting directly opposite D1527, so it was within</p> <p>10 his earshot, wasn't it, that comment?</p> <p>11 A. Yes.</p> <p>12 Q. You were in the cell. Do you remember hearing that?</p> <p>13 A. No.</p> <p>14 Q. Do you accept you would have done, in the circumstances?</p> <p>15 A. If I'd have heard it, I'd have questioned it.</p> <p>16 Q. Well, do you accept that, given it's picked up by</p> <p>17 DCO Tulley's camera on this footage, and that you were</p> <p>18 in the cell as well, that you would have heard it, in</p> <p>19 the circumstances?</p> <p>20 A. Possibly.</p> <p>21 Q. You didn't challenge DCM Loughton. You should have</p> <p>22 done, shouldn't you?</p> <p>23 A. If I'd heard it, I would have done, but I can't</p> <p>24 convinced -- I'm not convinced I heard it.</p> <p>25 Q. It was a completely inappropriate comment by him, wasn't</p> <p style="text-align: center;">Page 122</p>	<p>1 you had not appreciated that he was even making a joke</p> <p>2 and that your response "yeah" was because you had</p> <p>3 thought that you might be required to remain with D1527</p> <p>4 for some time and that it was clear you hadn't</p> <p>5 appreciated the nature of the comment by DCM Ring by the</p> <p>6 fact that he goes on to explain his comment after he</p> <p>7 makes it. Is that right? You didn't understand that he</p> <p>8 was making a joke at D1527's expense?</p> <p>9 A. No, I wouldn't have cottoned on to that at all.</p> <p>10 Q. If that's right and you didn't understand it initially,</p> <p>11 which caused him to explain it, you certainly knew by</p> <p>12 the time he'd explained it, didn't you?</p> <p>13 A. By the time he'd explained it.</p> <p>14 Q. Because, as you said, that's what you say in your</p> <p>15 witness statement, he explained it?</p> <p>16 A. Yes.</p> <p>17 Q. You didn't challenge him on that comment, did you?</p> <p>18 A. No.</p> <p>19 Q. Despite the fact it was said in front of D1527. Why</p> <p>20 not?</p> <p>21 A. I don't know.</p> <p>22 Q. Did you think it was appropriate for him to be making</p> <p>23 a joke about D1527, who had attempted to self-harm by</p> <p>24 swallowing a phone battery?</p> <p>25 A. No.</p> <p style="text-align: center;">Page 124</p>

<p>1 Q. If we can play, please, from 07:50 to 08:15, thank you.</p> <p>2 (Video played)</p> <p>3 MS SIMCOCK: I'm told there is still an issue with us</p> <p>4 hearing through the mics. If you could just try.</p> <p>5 I know it is difficult. If you could just try to keep</p> <p>6 your voice up, we'd be very grateful.</p> <p>7 What we just heard played on the footage was</p> <p>8 Nathan Ring referring to D1527 as a child. He says:</p> <p>9 "A child, you know [something inaudible] which isn't</p> <p>10 going to happen."</p> <p>11 You reply "No" and Nathan Ring says:</p> <p>12 "They just sit and sulk."</p> <p>13 In your witness statement, at page 8, you say you're</p> <p>14 not sure what you meant by "no", whether you were simply</p> <p>15 acknowledging that DCM Ring was speaking to you, or</p> <p>16 agreeing that the behaviour of D1527 would not result in</p> <p>17 his return to normal association, or the behaviour of</p> <p>18 D1527 would be more likely to result in a longer stay in</p> <p>19 E wing because it would not be considered safe for him</p> <p>20 to be on normal association. Weren't you there agreeing</p> <p>21 that D1527 was acting like a child?</p> <p>22 A. I don't see how.</p> <p>23 Q. Nathan Ring and Charlie Francis have both given evidence</p> <p>24 live to the inquiry that they thought he was behaving</p> <p>25 like a child and being manipulative. Was that your view</p> <p style="text-align: center;">Page 125</p>	<p>1 we, from the footage?</p> <p>2 A. Yes.</p> <p>3 Q. In your witness statement, you say, 22:58, which is the</p> <p>4 timing on not the counter, but the timing on the clip:</p> <p>5 "I can be seen leaving D1527's room but remain just</p> <p>6 outside the door."</p> <p>7 You don't mention in your witness statement anything</p> <p>8 about Nathan Ring's comment, do you?</p> <p>9 A. No, it probably would have gone straight over my head.</p> <p>10 Q. Nor the action he does, jumping up and down, presumably</p> <p>11 his impression of a Duracell bunny?</p> <p>12 A. It would have gone over my head. I probably wouldn't</p> <p>13 have noticed it.</p> <p>14 Q. But you clearly heard and saw it, as we can see from the</p> <p>15 footage?</p> <p>16 A. I will have heard and saw it and probably just passed it</p> <p>17 over, just let it go over my head.</p> <p>18 Q. It is clear he is making a joke at D1527's expense,</p> <p>19 isn't he? There is no question about that?</p> <p>20 A. Appears to be, yes.</p> <p>21 Q. Would you accept that that's inappropriate?</p> <p>22 A. Yes.</p> <p>23 Q. You didn't challenge him, we see from the footage. Why</p> <p>24 not?</p> <p>25 A. Because I suspect it's probably gone straight over my</p> <p style="text-align: center;">Page 127</p>
<p>1 of how he was behaving at the time?</p> <p>2 A. I don't know. I can't remember that in detail.</p> <p>3 Q. In your witness statement, you refer to D1527 staying on</p> <p>4 E wing due to his behaviour. Does that indicate a view</p> <p>5 that D1527 was deliberately acting inappropriately, as</p> <p>6 opposed to being in an acute mental crisis?</p> <p>7 A. No.</p> <p>8 Q. Did you think that D1527 was being treated appropriately</p> <p>9 by staff here?</p> <p>10 A. This was the first time I'd had any contact with D1527.</p> <p>11 Q. Is it appropriate to make these kind of comments about</p> <p>12 anyone who is suffering from mental illness and</p> <p>13 self-harming?</p> <p>14 A. No.</p> <p>15 Q. Can we play, please, from 14:07 to around about 14:18.</p> <p>16 (Video played)</p> <p>17 MS SIMCOCK: We see you there leaving the cell with</p> <p>18 Nathan Ring, don't we?</p> <p>19 A. Yes.</p> <p>20 Q. He, on leaving the cell, says, "Like a Duracell bunny,</p> <p>21 fully charged", and then he jumps up and down. Did you</p> <p>22 see that?</p> <p>23 A. Yes.</p> <p>24 Q. That's you in front of him when he makes that comment,</p> <p>25 and we can see that you see him jump up and down, can't</p> <p style="text-align: center;">Page 126</p>	<p>1 head as just part of day-to-day life in Brook House.</p> <p>2 Q. Acceptable?</p> <p>3 A. No. But normal.</p> <p>4 Q. Normal. Were you trying in your witness statement, by</p> <p>5 not mentioning your involvement in this inappropriate</p> <p>6 behaviour of staff towards him, to minimise that -- to</p> <p>7 distance yourself from that behaviour?</p> <p>8 A. No. I've got no reason to.</p> <p>9 Q. Can we look, please, at KENCOV1007, and it is the V</p> <p>10 number that ends in 21. This is the build-up to the</p> <p>11 incident in the cell with Yan Paschali. If we can play</p> <p>12 from around 01:26 to about 02:05.</p> <p>13 (Video played)</p> <p>14 MS SIMCOCK: I think with this one the two times are the</p> <p>15 same, so the clip time and the counter time are the</p> <p>16 same. Thank you.</p> <p>17 (Video played)</p> <p>18 MS SIMCOCK: So we see here that you're, again, outside</p> <p>19 D1527's cell, and you talk about doing the earlier form</p> <p>20 and visual obs, and you say in your statement that's</p> <p>21 a reference to the D213 form or the use of force form</p> <p>22 from the first incident that DCM Loughton attended the</p> <p>23 previous day. Do you think that's right?</p> <p>24 A. I wouldn't have completed a use of force form.</p> <p>25 Q. But do you think that reference is to the earlier</p> <p style="text-align: center;">Page 128</p>

<p>1 incident?</p> <p>2 A. I don't know. I don't think so. Maybe. I don't know.</p> <p>3 Q. Callum Tulley says:</p> <p>4 "Do you know what, actually, his problem is?"</p> <p>5 This is when you respond with the comment "He's an</p> <p>6 arse, basically", and you say, "He can't get what he</p> <p>7 wants. He can't get what he wants and I can't get what</p> <p>8 he wants."</p> <p>9 What you say about this in your statement, at</p> <p>10 page 11, is:</p> <p>11 "I regret referring to D1527 in this way and</p> <p>12 I apologise to him for doing so. However, the door to</p> <p>13 D1527's room was shut and there is no possibility he</p> <p>14 could have heard the comment."</p> <p>15 You accept it is still an inappropriate comment to</p> <p>16 make, even though he couldn't hear you?</p> <p>17 A. Yes, I do, and I have apologised for that.</p> <p>18 Q. "He can't get what he wants and I can't get what he</p> <p>19 wants", suggests his behaviour was deliberate, doesn't</p> <p>20 it, rather than as a result of mental ill-health?</p> <p>21 A. Maybe.</p> <p>22 Q. The comment was derogatory. Was this your</p> <p>23 genuinely-held view of him at the time?</p> <p>24 A. Probably not, no.</p> <p>25 Q. That he was being, effectively, deliberately annoying,</p> <p style="text-align: center;">Page 129</p>	<p>1 just to make sure he doesn't hurt himself.</p> <p>2 Q. If we could go forward then, please, to 06:14 and then</p> <p>3 play until 06:30.</p> <p>4 (Video played)</p> <p>5 MS SIMCOCK: In your witness statement at page 12, you note</p> <p>6 some of the comments by DCM Ring here, but not all of</p> <p>7 them, and you simply state:</p> <p>8 "Throughout these comments, I can be seen looking at</p> <p>9 the floor."</p> <p>10 Was there a reason you left out the comment about</p> <p>11 the battery being a dummy from your witness statement?</p> <p>12 A. Probably went over my head again. If you work in that</p> <p>13 environment, you kind of ignore a lot of the banter that</p> <p>14 goes on.</p> <p>15 Q. Yes.</p> <p>16 A. You can't take -- you can't take it on board. You just</p> <p>17 do what you're there to do.</p> <p>18 Q. Were you, in your witness statement to this inquiry,</p> <p>19 trying to minimise your complicity in inappropriate</p> <p>20 behaviour?</p> <p>21 A. Not at all.</p> <p>22 Q. You're inside the cell at this point, and clearly within</p> <p>23 earshot of D1527, aren't you?</p> <p>24 A. I should think so, yes.</p> <p>25 Q. Those are inappropriate comments by DCM Ring. Would you</p> <p style="text-align: center;">Page 131</p>
<p>1 causing you trouble, attention seeking?</p> <p>2 A. No.</p> <p>3 Q. Did you consider that he was in the middle of an acute</p> <p>4 mental health crisis at this stage?</p> <p>5 A. I considered he was probably unwell, yes.</p> <p>6 Q. Did you have in mind that he'd attempted suicide on</p> <p>7 three occasions in 24 hours and had refused food for six</p> <p>8 days before this?</p> <p>9 A. No, I didn't know anything about that.</p> <p>10 Q. If we could play, then, please, from 02:05 to 04:00,</p> <p>11 please.</p> <p>12 (Video played)</p> <p>13 MS SIMCOCK: In fact, we can pause there, thank you. This</p> <p>14 shows you and a number of different officers,</p> <p>15 DCOs Tulley and Fraser and DCMs Ring and Yates all</p> <p>16 observing D1527 from outside the cell and chatting to</p> <p>17 each other. Do you agree?</p> <p>18 A. Yes.</p> <p>19 Q. What was the purpose of you all being outside his cell</p> <p>20 at this point?</p> <p>21 A. I don't know.</p> <p>22 Q. Did you consider at the time the effect that that many</p> <p>23 people outside talking about him and observing him, the</p> <p>24 effect that it would have upon him?</p> <p>25 A. No, I'm just there for a medical perspective, not to --</p> <p style="text-align: center;">Page 130</p>	<p>1 agree?</p> <p>2 A. Yes, I would agree.</p> <p>3 Q. You didn't challenge them at the time, and you didn't</p> <p>4 report them. Why was that?</p> <p>5 A. Probably because they went over my head as banter.</p> <p>6 Q. Let's look, then, please, at 07:05 to 08:25, please, and</p> <p>7 this is the incident with Yan Paschali.</p> <p>8 (Video played)</p> <p>9 MS SIMCOCK: So Callum Tulley is left alone to observe D1527</p> <p>10 in his cell, and from about 07:08, he starts to</p> <p>11 self-strangulate, leading to the restraint in which</p> <p>12 Yan Paschali uses his hands on his neck, which has been</p> <p>13 referred to as "the choke hold incident". About this,</p> <p>14 you state the following in your statement at page 13,</p> <p>15 about the choke hold incident itself. You say:</p> <p>16 "[At] 00:08:23 -- the noises made by D1527 become</p> <p>17 louder and DCO Paschali is shown taking hold of D1527</p> <p>18 with his thumbs around D1527's neck/throat.</p> <p>19 DCO Paschali instructs D1527 to 'relax'. I did not see</p> <p>20 DCO Paschali's hands around D1527's neck or throat and</p> <p>21 had I seen this I would definitely have intervened to</p> <p>22 stop it. The same applies to the earlier occasion</p> <p>23 between 00:08:00 and 00:08:08, although it is not clear</p> <p>24 from the video whether DCO Paschali has his thumbs</p> <p>25 around D1527's throat during this period. I am certain</p> <p style="text-align: center;">Page 132</p>

1 that I was not in a position to see the hold on D1527's
2 neck because I know that I would have intervened
3 otherwise."
4 So your position now is that you couldn't see
5 DCO Paschali choking D1527 because you would have
6 intervened, had you seen it; is that right?
7 **A. Absolutely.**
8 Q. But you would have heard the choking sounds he is
9 making, wouldn't you?
10 **A. I would have heard the noise, but also I would have also**
11 **expected other officers there that had concerns to help**
12 **me with my -- being able to see to say something.**
13 Q. Did the noise he was making not concern you, as the
14 healthcare person there?
15 **A. Not at that moment.**
16 Q. Was that the usual sort of noise that a detainee would
17 make during a restraint?
18 **A. People do grunt and make noises.**
19 Q. But that's more than that, isn't it? It was a choking
20 noise?
21 **A. I can't recall that, and I'm not going to comment on**
22 **that.**
23 Q. Well, you have heard it on the footage --
24 **A. I'm not going to comment that it is a choking noise or**
25 **not.**

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1 Q. You don't want to?
2 **A. No, I'm not going to because I didn't see the restraint,**
3 **I didn't see -- if I had have done, I'd have stopped it.**
4 Q. However we describe it, whatever particular word we use,
5 we have just all heard it. That should have prompted
6 you to raise a concern, shouldn't it, in your
7 safeguarding role as the healthcare person there?
8 **A. If I'd heard it clearly or I'd had concerns that he was**
9 **being injured, yes, I would have done --**
10 Q. It was your --
11 **A. -- but I didn't, so ...**
12 Q. It was your responsibility to safeguard his welfare,
13 wasn't it?
14 **A. If I'd seen it, I would have stopped it, and if I'd**
15 **heard it, I would have stopped it.**
16 Q. Dealing with what you could see, at paragraph 42, you
17 say that there was a restraint involving four DCOs and
18 a detained person, all physically struggling in
19 a confined space. So you could see that?
20 **A. I could see the bodies, yes.**
21 Q. We know from the video footage, although you could see
22 that, you say nothing during the physical struggle, do
23 you? You don't raise any concerns throughout the
24 entirety of this incident, do you?
25 **A. No, not at that point.**

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1 Q. Did you not consider at the time that this struggle, as
2 you call it, might cause him harm, given his
3 vulnerability?
4 **A. I couldn't actually see what they were doing.**
5 Q. We will come to that in a moment. But you could see
6 that there was a struggle with four DCOs, as you have
7 described it. Didn't that concern you at the time?
8 **A. When it's that chaotic in that small a space and**
9 **I haven't got vision, I can't see. If I'd seen, I would**
10 **have stopped it. I'm not frightened to stop a C&R.**
11 Q. Why were you not advising this level of restraint to end
12 at this time?
13 **A. Because I couldn't actually see what was happening.**
14 Q. Did you make any efforts to try to reduce the risk of
15 harm to D1527, given what you could see?
16 **A. What do you mean?**
17 Q. Well, did you make any efforts at all to do anything to
18 reduce his risk of harm, given what you could see?
19 **A. I couldn't see hardly anything, so I can't comment. But**
20 **I can also say that officers -- there were three**
21 **officers there. One of them could have said, if they'd**
22 **had concerns, they could have raised concerns.**
23 **Callum Tulley could have raised concerns. He didn't.**
24 Q. We will come --
25 **A. And the other officers didn't.**

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1 Q. We will come to what Callum Tulley does in a moment.
2 But you are the healthcare person present, aren't you?
3 Your role, your safeguarding role, was to monitor his
4 welfare from a clinical perspective and to safeguard his
5 welfare by raising concerns. You didn't do anything in
6 that regard, did you?
7 **A. I can't raise a concern for what I don't see.**
8 Q. If we could play, please, from 08:25 to 08:42.
9 (Video played)
10 MS SIMCOCK: The Yan Paschali comment, "I'm going to put you
11 to fucking sleep", you say you didn't hear that.
12 **A. No, I didn't.**
13 Q. It is completely inappropriate, isn't it?
14 **A. It is an inappropriate comment, yes.**
15 Q. It is a direct threat. Do you agree?
16 **A. Yes.**
17 Q. You say, if you'd heard that, you would have intervened;
18 is that right?
19 **A. Absolutely, yes.**
20 Q. Even though you didn't intervene when other
21 inappropriate comments were made in your presence?
22 **A. Those I've described to you as -- just washed over like**
23 **banter. But that was inappropriate. But I would have**
24 **expected somebody else to have mentioned that that had**
25 **been heard, just to make me aware of it.**

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34 (Pages 133 to 136)

<p>1 Q. In relation to DCO Tulley, you have said he didn't 2 intervene. He clearly instructs DCO Paschali, "Easy, 3 easy", doesn't he? 4 A. He does, but could he have not -- 5 Q. Did that not concern you? 6 A. Because I wouldn't have heard that. Could he not have 7 turned to me and said, "Jo, I think something is 8 happening here. Can you have a look". 9 Q. We heard it on the footage. It is quite a loud command, 10 "Yan, easy, easy". You still say you didn't hear that? 11 A. I don't think it was very loud. 12 Q. If we, please, just go back a few seconds. If you could 13 keep your eyes, please, on the right-hand side of 14 the picture, and if we just play it again through to 15 08:43. 16 (Video played) 17 MS SIMCOCK: Did you see there that to the right of 18 Yan Paschali kneeling there was an individual in the 19 picture standing, with their feet and legs visible? 20 A. Yes. 21 Q. As we play the footage, you can see that the individual 22 walks around from behind Yan Paschali to his left, and 23 by the time they're past him, they would have had a view 24 of where his hands were on D1527's neck. Do you agree 25 with that?</p> <p style="text-align: center;">Page 137</p>	<p>1 shouldn't you? 2 A. Look, in that environment, you work with this day in, 3 day out, and this is a normal working environment, and 4 after a while, you just go in, do your job. 5 Q. But you weren't doing your job? 6 A. I was doing my job. 7 Q. Your job, as a nurse, was to challenge inappropriate 8 behaviour towards this detainee in your safeguarding 9 role as the nurse present, wasn't it? 10 A. If I'd seen it -- 11 Q. That was your job? 12 A. If I'd seen it, I would have challenged it. If I'd 13 realised it, I would have challenged it. 14 Q. At 00:09:09 minutes, D1527 says, "My neck, my neck". 15 You say: 16 "I do not believe that I heard this comment, or 17 I would have intervened. At this point DCO Paschali's 18 hands are along the sides of D152's jaw and it can be 19 seen that no pressure is being exerted by his thumbs." 20 In fact, D1527 says "my neck" another three times 21 between 00:09:14 and 00:09:16. Do you agree with that 22 from the footage? 23 A. Yes. 24 Q. You're in the cell at this point, as we have just 25 established, to the side of Yan Paschali. You would</p> <p style="text-align: center;">Page 139</p>
<p>1 A. Yes. 2 Q. That's you, isn't it? 3 A. That is me. 4 Q. So you would have had a view of Yan Paschali's hands on 5 D1527's neck, wouldn't you? 6 A. No, not necessarily. I say -- 7 Q. Why not? 8 A. As I say to you, if I'd seen it, I would have stopped 9 it. 10 Q. What you can see is him being pinned on the floor by the 11 officers present. You still didn't raise any concerns 12 at this point. Why not? 13 A. I obviously wasn't aware of it. I'd have stopped it -- 14 I'd stopped many a C&R. I had no reason not to. 15 Q. Can we play from 08:55 -- well, from here is fine, to 16 09:30, please. 17 (Video played) 18 MS SIMCOCK: So Charlie Francis here asks, "Are you going to 19 stop being a tool now? Stop being an idiot?" That was 20 loud and in your hearing, wasn't it? 21 A. Possibly. 22 Q. You don't challenge Charlie Francis about that language. 23 Why not? 24 A. Probably would have washed straight over my head again. 25 Q. You didn't report him. Again, you should have done,</p> <p style="text-align: center;">Page 138</p>	<p>1 have heard that, wouldn't you? 2 A. That, I don't know. Possibly. 3 Q. Did that not concern you, that he's been subject to 4 restraint and he's complaining about his neck? 5 A. Yes, it would have done. 6 Q. Yet you don't raise any concerns or intervene in any 7 way. You should have done, shouldn't you? 8 A. I can't intervene until he's calm. 9 Q. You wouldn't intervene, when a detainee was complaining 10 about their neck during a restraint, to stop the 11 restraint? 12 A. I thought you said the restraint had stopped? 13 Q. The restraint had stopped, in your view? 14 A. No, you just said that, didn't you? Sorry. 15 Q. He's still being restrained on the floor, isn't he, when 16 he says, "My neck, my neck", five times? Yan Paschali 17 is still kneeling there. We can play it again, if you 18 like? 19 A. Yes, please, if you could. 20 Q. Can we go back to about 9 minutes, please. 21 (Video played) 22 MS SIMCOCK: He's still being restrained by Yan Paschali 23 around his jaw and neck, isn't he, when he says, "My 24 neck, my neck" five separate times? 25 A. Okay.</p> <p style="text-align: center;">Page 140</p>

<p>1 Q. You didn't intervene to stop that. Why not?</p> <p>2 A. Maybe I didn't hear it. If I'd heard it, seen it,</p> <p>3 I would have done. If I was by the door, I wouldn't</p> <p>4 have noticed or heard it.</p> <p>5 Q. Again, is the reason that you haven't mentioned in your</p> <p>6 statement what Charlie Francis says in your presence</p> <p>7 loudly that it's derogatory and you failed to challenge</p> <p>8 it at the time?</p> <p>9 A. No, because it would have washed over my head, as I said</p> <p>10 before.</p> <p>11 Q. It is inappropriate to call a detainee a "tool", isn't</p> <p>12 it?</p> <p>13 A. Yes.</p> <p>14 Q. It is inappropriate not to challenge that behaviour by</p> <p>15 other staff members, isn't it?</p> <p>16 A. If you're aware of it, but it's day to day. You almost</p> <p>17 become immune.</p> <p>18 Q. So you weren't reporting it when you should have done?</p> <p>19 A. But you almost become immune to what's going on there.</p> <p>20 You just do your job and go away.</p> <p>21 Q. So you didn't report it when you should have done; is</p> <p>22 that right?</p> <p>23 A. No, I disagree with that.</p> <p>24 Q. In relation to the monitoring role that I have asked you</p> <p>25 about in relation to the use of force upon D1527,</p> <p style="text-align: center;">Page 141</p>	<p>1 A. In a small, chaotic area, you have to be the safest</p> <p>2 point that you can try and observe. It's not --</p> <p>3 Q. It was -- sorry.</p> <p>4 A. No, go on.</p> <p>5 Q. It was particularly important to be able to see the</p> <p>6 detainee's face and neck, wasn't it? During</p> <p>7 a restraint, during force used upon a detainee, where</p> <p>8 their head is being controlled in the use of force and</p> <p>9 restraint is being applied, it's particularly important</p> <p>10 to be able to see their face and neck, isn't it?</p> <p>11 A. Yes.</p> <p>12 Q. Because how else are you to assess their breathing, for</p> <p>13 example? You would agree with that?</p> <p>14 A. You can assess breathing from the chest.</p> <p>15 Q. Isn't it important to be able to see whether anything is</p> <p>16 obstructing their airway or whether force is being</p> <p>17 applied inappropriately to someone's neck, given how</p> <p>18 dangerous that is?</p> <p>19 A. Yes.</p> <p>20 Q. It is also important to be monitoring their welfare in</p> <p>21 terms of their levels of distress, isn't it? If you</p> <p>22 can't see their face, it is more difficult to assess</p> <p>23 whether they're distressed or not; is that right?</p> <p>24 A. It is, but you can't always see.</p> <p>25 Q. Well, you didn't put yourself in a position to be able</p> <p style="text-align: center;">Page 143</p>
<p>1 assuming that it's accepted, what you now say, that you</p> <p>2 couldn't see the hold by Yan Paschali on D1527's neck</p> <p>3 and you couldn't hear either what Yan Paschali said to</p> <p>4 him or D1527 saying, "My neck, my neck", how were you</p> <p>5 monitoring the use of force upon him?</p> <p>6 A. Visually.</p> <p>7 Q. But you couldn't see?</p> <p>8 A. What I can see. I can only see -- if I'm by the door,</p> <p>9 I can only see visually.</p> <p>10 Q. The monitoring of the use of force by healthcare staff</p> <p>11 present is an important safeguarding role, isn't it, of</p> <p>12 the welfare of a vulnerable detainee?</p> <p>13 A. Yes.</p> <p>14 Q. It's an important protective duty to raise concerns in</p> <p>15 relation to a restraint because nurses have the power,</p> <p>16 and indeed obligation, to stop a use of force and say,</p> <p>17 "A medical emergency. Hands off" and detention staff</p> <p>18 are expected to comply with that; that's right, isn't</p> <p>19 it?</p> <p>20 A. That's right.</p> <p>21 Q. If we are to believe what you now say, that you couldn't</p> <p>22 see and you couldn't hear, you had a responsibility,</p> <p>23 didn't you, to put yourself in a position where you were</p> <p>24 able to see and hear what was going on in this</p> <p>25 restraint?</p> <p style="text-align: center;">Page 142</p>	<p>1 to see, did you, on what you now say to the inquiry?</p> <p>2 That's right, isn't it?</p> <p>3 A. Because there wasn't another position for me to be in.</p> <p>4 Q. And you didn't raise any concerns with the officers,</p> <p>5 "Look, I can't see. You need to move", or, "I need to</p> <p>6 be able to get through to be able to see". You didn't</p> <p>7 raise any concern of that nature?</p> <p>8 A. There was nowhere else to move to.</p> <p>9 Q. You could have stopped the restraint, "You have to stop</p> <p>10 the restraint if I can't see and monitor his welfare".</p> <p>11 You didn't do that, did you?</p> <p>12 A. If I'd seen it and noted it, I would have always stopped</p> <p>13 the restraint.</p> <p>14 Q. But what I'm suggesting --</p> <p>15 A. I've done that a lot of times.</p> <p>16 Q. -- what I'm suggesting is, because you couldn't see, you</p> <p>17 therefore couldn't fulfil your safeguarding monitoring</p> <p>18 role and so you should have stopped it in those</p> <p>19 circumstances, shouldn't you?</p> <p>20 A. I'm not going to answer that because I don't recall that</p> <p>21 incident that clearly.</p> <p>22 Q. The safeguards available to him in the form of you</p> <p>23 monitoring his health and welfare during this restraint</p> <p>24 completely failed him, didn't they, because you couldn't</p> <p>25 see or hear what was happening to him; that's right,</p> <p style="text-align: center;">Page 144</p>

<p>1 isn't it?</p> <p>2 A. They wouldn't have been at their best.</p> <p>3 Q. Not at their best. Did you ever attend any G4S training</p> <p>4 on control and restraint at all?</p> <p>5 A. Break-away techniques.</p> <p>6 Q. Did you ever receive any training on what types of</p> <p>7 techniques and what level of force was appropriate for</p> <p>8 the use on vulnerable detainees? Was there any training</p> <p>9 on that --</p> <p>10 A. I don't know. I don't think so.</p> <p>11 Q. You don't think so. Did you ever ask to be trained in</p> <p>12 that regard?</p> <p>13 A. I don't know. I can't remember.</p> <p>14 Q. How would you have known that force used -- force being</p> <p>15 used was excessive in order to make the decision to stop</p> <p>16 the use of force if you weren't familiar with when</p> <p>17 control and restraint could be used and what level it</p> <p>18 could be used to?</p> <p>19 A. I don't know.</p> <p>20 Q. Could we look, then, please, at the same video, from</p> <p>21 09:30 to 10:00, please.</p> <p>22 (Video played)</p> <p>23 MS SIMCOCK: D1527 is forcibly put into the recovery</p> <p>24 position here. He is clearly in very severe distress</p> <p>25 here, isn't he?</p> <p style="text-align: right;">Page 145</p>	<p>1 condition couldn't be adequately managed at Brook House?</p> <p>2 A. Absolutely, yeah, yeah.</p> <p>3 Q. Did you take any steps to raise that concern about D1527</p> <p>4 with anyone?</p> <p>5 A. Probably not, because he was already under the care of</p> <p>6 the RMNs, who were looking after him. He wasn't known</p> <p>7 to the general healthcare staff.</p> <p>8 Q. You were clinical lead?</p> <p>9 A. I wasn't at that time.</p> <p>10 Q. You were a senior nurse of 38 years' experience. You</p> <p>11 would have known of the way to raise such concerns.</p> <p>12 Didn't you consider it was your duty to do so, as the</p> <p>13 nurse attending this incident and holding that view,</p> <p>14 that he couldn't adequately be managed in Brook House?</p> <p>15 Shouldn't you have raised a concern?</p> <p>16 A. With hindsight.</p> <p>17 Q. D1527, we can hear, continues to cry and scream. What</p> <p>18 we next here is DCO Francis saying, "We're getting bored</p> <p>19 now. What are you, a man or a mouse? Stop being</p> <p>20 a baby. Stop being a baby". We can play it if you</p> <p>21 would like, but you don't address those comments in your</p> <p>22 witness statement. Why was that?</p> <p>23 A. I don't know. Again, just banter over the head.</p> <p>24 Q. They're inappropriate, aren't they?</p> <p>25 A. Yes.</p> <p style="text-align: right;">Page 147</p>
<p>1 A. Appears to be, yes.</p> <p>2 Q. This is evidently someone who is mentally unwell.</p> <p>3 That's obvious, isn't it? Yes?</p> <p>4 A. Yes.</p> <p>5 Q. That didn't concern you at the time sufficient to raise</p> <p>6 a concern at this stage that the force should cease?</p> <p>7 A. I honestly can't remember. I've said, if I'd known and</p> <p>8 been aware of it, I would have stopped it.</p> <p>9 Q. If we look, please, at 12:00 minutes, and if we can play</p> <p>10 to 12:28, please.</p> <p>11 (Video played)</p> <p>12 MS SIMCOCK: Just dealing with what you can see and hear</p> <p>13 here, you see where you are in relation to him. You can</p> <p>14 hear on the footage what he sounds like. You must have</p> <p>15 heard this, do you accept?</p> <p>16 A. I accept that.</p> <p>17 Q. You say, and you say in your statement, that you say,</p> <p>18 "He needs to go to HMP, back to Belmarsh", and you say</p> <p>19 that that's because HMP Belmarsh has better facilities</p> <p>20 than Brook House and it had inpatient healthcare. So</p> <p>21 you recognised at the time, both that his presentation</p> <p>22 here was due to underlying mental ill-health, didn't</p> <p>23 you --</p> <p>24 A. I recognised he was unwell.</p> <p>25 Q. -- and that that was an indication that you thought his</p> <p style="text-align: right;">Page 146</p>	<p>1 Q. And you didn't challenge them at the time. You should</p> <p>2 have done, shouldn't you?</p> <p>3 A. Again, if I'd probably been fully aware of them, yes.</p> <p>4 Q. If we play the footage, please, from 27:00 minutes to</p> <p>5 27:49.</p> <p>6 (Video played)</p> <p>7 MS SIMCOCK: This is you talking to DCO Tulley after the</p> <p>8 incident in the staff room. Do you recognise that?</p> <p>9 A. That's not in the staff room.</p> <p>10 Q. Sorry, where is it?</p> <p>11 A. That's, I think -- if you play it again, I think you'll</p> <p>12 find that's on E wing.</p> <p>13 Q. It's you having a conversation with DCO Tulley about</p> <p>14 recording the use of force. You say at 27:03 minutes:</p> <p>15 "Are they putting that down as a restraint?"</p> <p>16 Why did you ask if they were going to put the</p> <p>17 incident down as a restraint?</p> <p>18 A. I just assumed they would be, because it was down to</p> <p>19 DCO Tulley to do the form.</p> <p>20 Q. Was there any doubt that he had been restrained?</p> <p>21 A. No.</p> <p>22 Q. So why are you asking about it?</p> <p>23 A. I don't know.</p> <p>24 Q. Because even if nothing inappropriate had been done by</p> <p>25 Yan Paschali, or indeed anyone else, or if something</p> <p style="text-align: right;">Page 148</p>

<p>1 inappropriate had been done but not seen by you, there's</p> <p>2 no question that this is properly described as</p> <p>3 a restraint, isn't there? This was a restraint?</p> <p>4 A. This was a restraint, yes.</p> <p>5 Q. So why are you asking if they are going to put it down</p> <p>6 as a restraint?</p> <p>7 A. I don't know.</p> <p>8 Q. A use of force form has to be filled in whenever any</p> <p>9 force or restraint is used. It's mandatory?</p> <p>10 A. They do.</p> <p>11 Q. Callum Tulley's answer was effectively, "No, it's not as</p> <p>12 it stands, it's not being recorded as a restraint".</p> <p>13 That's what you understood him to be saying --</p> <p>14 A. And Callum Tulley should have a use of force form.</p> <p>15 Q. I'm not asking about who should have done it. I'm</p> <p>16 asking about what you understood him to be saying. You</p> <p>17 understood him to be saying, from his answer, that he</p> <p>18 wasn't going to record it as a restraint, didn't you?</p> <p>19 A. Yes.</p> <p>20 Q. Did that not concern you?</p> <p>21 A. Yes, it would have done.</p> <p>22 Q. Why didn't you do anything about that concern?</p> <p>23 A. In what way?</p> <p>24 Q. Well, what could you have done about that concern at the</p> <p>25 time, do you consider, as a nurse of 38 years'</p> <p style="text-align: center;">Page 149</p>	<p>1 me", and we accept that it's "my hand isn't going to let</p> <p>2 me" and so the transcript has been amended. But that</p> <p>3 comment about you not writing any more because your hand</p> <p>4 isn't going to let you was in the context of asking</p> <p>5 a question about whether officers were recording</p> <p>6 a restraint and receiving the answer "no", isn't it?</p> <p>7 A. No, it isn't, it's because I have arthritis in my hands</p> <p>8 and my hands were very painful at that time.</p> <p>9 Q. Does that indicate that you didn't record as fully as</p> <p>10 you should have done if you had had an uninjured hand?</p> <p>11 A. My ACDT documentation was adequate, as found by the</p> <p>12 Home Office and by healthcare manager.</p> <p>13 Q. You were reading to Callum Tulley from your ACDT entry,</p> <p>14 weren't you?</p> <p>15 A. I was.</p> <p>16 Q. And you said, "A T-shirt around his neck, angry and</p> <p>17 upset. He may have phone battery in his mouth.</p> <p>18 Attempted to self-strangulate on toilet. Visual</p> <p>19 observations only due to demeanour. Yeah, that's all</p> <p>20 I can say, isn't it? It still hasn't been done properly</p> <p>21 so I don't know."</p> <p>22 You say in your witness statement that the</p> <p>23 comment -- you believe the comment "It still hasn't been</p> <p>24 done properly" may be a reference to the fact there</p> <p>25 should have been an incident report and a use of force</p> <p style="text-align: center;">Page 151</p>
<p>1 experience? You could have said to him, something along</p> <p>2 the lines of, "But, Callum, it was a restraint, wasn't</p> <p>3 it?"</p> <p>4 A. I could have done.</p> <p>5 Q. "And you have to fill the form out, because it's</p> <p>6 mandatory". You didn't say that, did you?</p> <p>7 A. No.</p> <p>8 Q. Why not?</p> <p>9 A. I don't know.</p> <p>10 Q. Don't you have a duty to report that, that he's not</p> <p>11 going to fulfil his obligation to fill out the form?</p> <p>12 A. I don't think so.</p> <p>13 Q. Why not?</p> <p>14 A. Because it's a DCO role, isn't it? It's not</p> <p>15 a healthcare role.</p> <p>16 Q. But as your NMC standards say, you have a duty to</p> <p>17 challenge inappropriate behaviour amongst other staff,</p> <p>18 don't you?</p> <p>19 A. Does that relate to all staff or just healthcare staff?</p> <p>20 Q. Well, you tell me.</p> <p>21 A. I don't know. I don't have any access to NMC Codes or</p> <p>22 anything now.</p> <p>23 Q. In relation to the statement, "I can't write anymore</p> <p>24 because my hand isn't going to let me", the inquiry</p> <p>25 initially transcribed that as "Yan's not going to let</p> <p style="text-align: center;">Page 150</p>	<p>1 form, but you say that's not your responsibility. But</p> <p>2 we have just established that you didn't say to anyone</p> <p>3 that they should fulfil their responsibilities in</p> <p>4 filling out a use of force form, did you?</p> <p>5 A. Probably not.</p> <p>6 Q. You didn't report to anyone that no use of force form</p> <p>7 had been filled in by them as required, did you?</p> <p>8 A. No, I had my own paperwork to do.</p> <p>9 Q. But wasn't that part of your responsibility to D1527?</p> <p>10 A. To complete the use of force form? No.</p> <p>11 Q. To ensure that you reported inappropriate behaviour by</p> <p>12 staff in not completing the form?</p> <p>13 A. My responsibility was completing the three lots of</p> <p>14 paperwork I completed for him.</p> <p>15 Q. You say, at paragraph 21(e) on page 20 of your</p> <p>16 statement, that it was open for DCO Tulley to disagree</p> <p>17 with what you wrote or to seek to add to it on the ACDT.</p> <p>18 A. That's right.</p> <p>19 Q. But DCOs, you're aware, aren't you, aren't clinically</p> <p>20 trained?</p> <p>21 A. The ACDT is an open document, it is a public document.</p> <p>22 It's not -- and they are trained in ACDT writing.</p> <p>23 Q. Were you aware that DCOs weren't clinically trained, is</p> <p>24 the question?</p> <p>25 A. Yes.</p> <p style="text-align: center;">Page 152</p>

<p>1 Q. They are not given, or they are only given very limited,</p> <p>2 mental health awareness training, aren't they? Were you</p> <p>3 aware of that at the time?</p> <p>4 A. No, but ...</p> <p>5 Q. Callum Tulley was a young, inexperienced DCO working in</p> <p>6 activities, and you'd been a nurse for 38 years, and you</p> <p>7 didn't challenge him when he said he wasn't going to be</p> <p>8 recording the restraint, did you?</p> <p>9 A. No. Probably not.</p> <p>10 Q. Are you really saying that you expected him to disagree</p> <p>11 with what you wanted to put in your entry in the ACDT in</p> <p>12 those circumstances?</p> <p>13 A. No, but I would have expected him, if he'd needed to, to</p> <p>14 write a comment of his own.</p> <p>15 Q. Are you relying upon his lack of challenge to your note</p> <p>16 for the appropriateness of that note?</p> <p>17 A. My note was appropriate.</p> <p>18 Q. There's no mention in your entry in the ACDT of</p> <p>19 a restraint, is there? No mention at all of a use of</p> <p>20 force?</p> <p>21 A. No, but my note has been deemed acceptable.</p> <p>22 Q. Do you think that "angry and upset" accurately describes</p> <p>23 what we have just seen on the footage D1527's condition</p> <p>24 and presentation in this incident?</p> <p>25 A. In a public document, yes.</p> <p style="text-align: center;">Page 153</p>	<p>1 Q. You still say that's adequate?</p> <p>2 A. I still say that's adequate.</p> <p>3 Q. Do you think that adequately reflects his full</p> <p>4 presentation that we see on the footage?</p> <p>5 A. I think it's adequate for what I've written.</p> <p>6 Q. Is the pain in your hand the real reason you didn't</p> <p>7 write a full note?</p> <p>8 A. I have arthritis and fibromyalgia. I was under the care</p> <p>9 of a rheumatologist and just starting medication --</p> <p>10 Q. Was that the question --</p> <p>11 A. -- so yes, I do have severe pain in my hands.</p> <p>12 Q. What I'm asking is a different question, Ms Buss: was</p> <p>13 pain in your hands the reason you didn't write a full</p> <p>14 and accurate note?</p> <p>15 A. Yes.</p> <p>16 Q. It was your responsibility and duty to the patient to do</p> <p>17 so, though, wasn't it?</p> <p>18 A. My notes were accurate. They might have been short, but</p> <p>19 they were accurate.</p> <p>20 Q. Had you raised your inability to do your record keeping</p> <p>21 adequately, because of the pain in your hand, with your</p> <p>22 management?</p> <p>23 A. Yes.</p> <p>24 Q. What was their response?</p> <p>25 A. Sent me for an occupational health review.</p> <p style="text-align: center;">Page 155</p>
<p>1 Q. "Angry and upset"?</p> <p>2 A. Yes.</p> <p>3 Q. That's what he looks like to you on the footage, is it?</p> <p>4 A. If I put anything medically in there, it would be, "Oh,</p> <p>5 you're writing medical in confidence". It is an open</p> <p>6 document that you could write in, anybody could write</p> <p>7 in.</p> <p>8 Q. You could have put "severe distress", couldn't you?</p> <p>9 A. Possibly.</p> <p>10 Q. You say at paragraph 21(d) at page 20:</p> <p>11 "The handwritten record was brief, not because I was</p> <p>12 seeking to cover up the facts but because I was</p> <p>13 suffering pain in my hand. I suffer from arthritis and</p> <p>14 fibromyalgia which made writing difficult."</p> <p>15 But that's not a legitimate reason to leave out the</p> <p>16 restraint, is it?</p> <p>17 A. I did mention it. I think -- did I not say something</p> <p>18 about things being moved by officers or something?</p> <p>19 Q. "ACDT. Seen in room 7. Constant watch. D1527 had tied</p> <p>20 a T-shirt around his neck. Angry, upset. Had mobile</p> <p>21 phone battery in his mouth. Attempted to</p> <p>22 self-strangulate in toilet. Visual observations only</p> <p>23 due to demeanour. Resps 16."</p> <p>24 No mention at all of a restraint there, is there?</p> <p>25 A. No, but it was an adequate ...</p> <p style="text-align: center;">Page 154</p>	<p>1 MS SIMCOCK: That may be a convenient moment for a break,</p> <p>2 chair. 3.20 pm, please?</p> <p>3 THE CHAIR: Thank you very much.</p> <p>4 (3.07 pm)</p> <p>5 (A short break)</p> <p>6 (3.24 pm)</p> <p>7 MS SIMCOCK: Could we have on screen <CJS001002> at page 38,</p> <p>8 please. The bottom half of the page, please.</p> <p>9 Ms Buss, this is D1527's medical record. We see</p> <p>10 there your entry for 15 April, timed at 18:51. The note</p> <p>11 that you made there:</p> <p>12 "Examination: placed on rule 40 constant supervision</p> <p>13 as he refused to return to E wing. Called to E wing at</p> <p>14 [approximately] 19:00. Constant watch. Had placed</p> <p>15 a ligature around his neck. Removed by staff. Staff</p> <p>16 trying to engage with him. RMN Dalia tried to engage</p> <p>17 with him with minimal effect. Put mobile phone battery</p> <p>18 in his mouth which he later removed battery removed from</p> <p>19 his room. Went to toilet and attempted to</p> <p>20 self-strangulate. Angry and not engaging with staff.</p> <p>21 Hands removed from his neck by staff. Salivating + +.</p> <p>22 Unable to take any observations. Visual obs resps 16.</p> <p>23 Slight redness noted on his neck. 20:00 got up and</p> <p>24 walked around room. Taken a small drink. Restless.</p> <p>25 Constant watch continues. Not engaging with staff.</p> <p style="text-align: center;">Page 156</p>

<p>1 Plan: please review later this evening."</p> <p>2 There's no mention there of a restraint, is there?</p> <p>3 A. "Hands removed from his neck by staff".</p> <p>4 Q. No mention of a use of force to do so; do you agree?</p> <p>5 A. No, but it's self-explanatory, isn't it? His hands have</p> <p>6 been removed by staff.</p> <p>7 Q. So the description that you recorded "Hands removed from</p> <p>8 his neck by staff", are you saying that that accurately</p> <p>9 conveys what we see happen on the footage we have just</p> <p>10 viewed?</p> <p>11 A. No.</p> <p>12 Q. It doesn't go anywhere near to record the true nature of</p> <p>13 what happened to D1527 during this incident, does it?</p> <p>14 A. No, it could have been fuller, couldn't it?</p> <p>15 Q. It entirely minimises the seriousness of the use of</p> <p>16 force against him, doesn't it?</p> <p>17 A. I think my notes could have been better.</p> <p>18 Q. Any healthcare staff reading that entry afterwards who</p> <p>19 was not present at this incident would have been</p> <p>20 completely unable to understand the full nature of it,</p> <p>21 wouldn't they? The length of it, for example, that four</p> <p>22 officers had used a significant level of force on D1527</p> <p>23 and the level of his distress. They wouldn't understand</p> <p>24 any of that from this entry, would they?</p> <p>25 A. It could have been fuller.</p> <p style="text-align: center;">Page 157</p>	<p>1 today and no medical problems. I believe he presented</p> <p>2 with challenging behaviour overnight but settled and</p> <p>3 later became co-operative."</p> <p>4 Would you agree that that seems to be a note of what</p> <p>5 was quite a superficial and brief review by</p> <p>6 Dr Oozeerally of this patient?</p> <p>7 A. I can't comment on it. I don't know what the</p> <p>8 conversation was between Dr Oozeerally and the patient.</p> <p>9 Q. Well, all he says is:</p> <p>10 "He says he feels well today and no medical</p> <p>11 problems."</p> <p>12 Then he records that he was aware of challenging</p> <p>13 behaviour overnight. That doesn't indicate an in-depth</p> <p>14 examination, does it?</p> <p>15 A. I don't know what his verbal communication with the</p> <p>16 detainee would have been, so I can't comment.</p> <p>17 Q. Do you think that the doctor would have known to do</p> <p>18 a more in-depth mental state examination had your note</p> <p>19 been fuller, as you put it, in terms of his presentation</p> <p>20 the previous day?</p> <p>21 A. I can't comment on what the doctor would know or not</p> <p>22 know.</p> <p>23 Q. Well, all he would know is what's in your record,</p> <p>24 wouldn't he?</p> <p>25 A. He'd know -- I suspect he's probably spoken to him or</p> <p style="text-align: center;">Page 159</p>
<p>1 Q. You record "Salivating + +". How were you able to</p> <p>2 ascertain that, if you couldn't see his face and neck</p> <p>3 during the restraint?</p> <p>4 A. That would be when he was given a drink, maybe. I don't</p> <p>5 know. It's five years ago.</p> <p>6 Q. You say you could only visually observe D1527 because of</p> <p>7 his demeanour in your statement. There's no recording</p> <p>8 of any mental health concern here, given the nature of</p> <p>9 his demeanour, is there?</p> <p>10 A. Apart from the fact he's "Angry and upset".</p> <p>11 Q. This was someone --</p> <p>12 A. "Angry and not engaging".</p> <p>13 Q. -- who had tried to kill himself. He had been</p> <p>14 incredibly distressed, screaming and crying, as we have</p> <p>15 seen on the footage, obviously extremely unwell. That</p> <p>16 note simply doesn't accurately convey that underlying</p> <p>17 mental health presentation, does it?</p> <p>18 A. Could have been fuller.</p> <p>19 Q. Dr Oozeerally saw D1527 the next morning, and if we just</p> <p>20 go over the page to page 39, please, and up to the top,</p> <p>21 on 26 April, between a third and half the way down the</p> <p>22 page, do you see Dr Oozeerally -- thank you. That's</p> <p>23 Dr Oozeerally's entry, when he saw him on E wing, and he</p> <p>24 says:</p> <p>25 "History: seen in E wing. He says he feels well</p> <p style="text-align: center;">Page 158</p>	<p>1 maybe the staff on E wing. I don't know. I can't</p> <p>2 answer that.</p> <p>3 Q. In relation to, then, the use of force form, could we</p> <p>4 please look at <CJS005534> at page 10, please. This is</p> <p>5 the form that is -- a use of force form that is to</p> <p>6 record a report of injury to a detainee, and, as you</p> <p>7 see -- as you have said, this part of the form is blank</p> <p>8 because the detention staff didn't fill it in. If we go</p> <p>9 over the page, please, this is the healthcare section,</p> <p>10 isn't it?</p> <p>11 A. Yes.</p> <p>12 Q. Section 3. It says:</p> <p>13 "Healthcare's report (to be completed by medical</p> <p>14 staff)."</p> <p>15 It has the time and date of examination,</p> <p>16 25 April 2017 at 19:00. That would have been the date</p> <p>17 of the incident, the date and time of the incident?</p> <p>18 A. It wouldn't have been the time. The time was later than</p> <p>19 that.</p> <p>20 Q. I see. It should have been the time of the incident or</p> <p>21 it should have been the time of the examination on the</p> <p>22 detainee after the incident?</p> <p>23 A. I don't know, but we know the time was later.</p> <p>24 Q. This is, as we know, Mariola Makucka, another nurse's</p> <p>25 entry, which you say you caused her to write on your</p> <p style="text-align: center;">Page 160</p>

1 behalf; is that right?

2 **A. Yes, I would have asked her to do that for me.**

3 Q. Did you approve this entry once she'd done it?

4 **A. No, she would have done it.**

5 Q. Why not, given it records your attendance at this use of

6 force and not hers?

7 **A. She was there part of the time.**

8 Q. But it's an entry on your behalf, that you say you

9 caused her to write?

10 **A. I asked her to write it. She was on the night shift, so**

11 **she probably wrote it in the evening. I don't know.**

12 Q. If we look at what it says then:

13 "Seen on E wing room 7 by RGN Jo."

14 That's you:

15 "Detainee had placed a ligature around his neck,

16 removed by staff. After this he went to toilet and

17 attempt to self-strangulate. Hands removed from his

18 neck. Slightly redness noted on his neck."

19 Given this is recorded in a use of force form,

20 I suppose we can at least understand that force was used

21 upon D1527 during this incident. Again, do you accept

22 that this brief note in no way confirms or conveys the

23 seriousness of the incident that we actually see on the

24 footage?

25 **A. I think, again, it could have been fuller.**

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1 Q. It didn't meet the standards required of you, did it?

2 Do you accept that?

3 **A. No, I don't. I think it's --**

4 Q. You think this is adequate in conveying what we see on

5 the footage in relation to this incident?

6 **A. In relation to the incident, probably not.**

7 Q. Had we not got the footage of this incident from

8 Callum Tulley's undercover camera, we would have no

9 appreciation from the totality of your documentation in

10 the three records you document in of the true nature and

11 seriousness of this incident, would we?

12 **A. I'm very grateful you have that footage.**

13 Q. As are we. A rule 35(3) report was completed for D1527

14 by Dr Oozeerally on 13 April, recorded in his medical

15 records. Were you aware of that on the 25th when you

16 attended?

17 **A. No.**

18 Q. Why not, given it is in his medical records?

19 **A. Because he would be part of the mental health team and**

20 **it wouldn't be common knowledge for everybody to know in**

21 **the department.**

22 Q. You seemed to know something about him, though, because

23 you knew he'd been at HMP Belmarsh, didn't you?

24 **A. Yes.**

25 Q. Because you say that in the footage.

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1 **A. Yes.**

2 Q. Do you think that you had met him before this date?

3 **A. No, I definitely hadn't.**

4 Q. How can you be so sure of that, given your problems with

5 memory from this time?

6 **A. Well, anybody you meet, you document.**

7 Q. You assessed D1527 as suitable for rule 40 removal from

8 association just a couple of hours before the incident

9 with Yan Paschali. Do you remember that?

10 **A. I believe, and I wouldn't be sure, that I was asked to**

11 **complete that form because I think that form should have**

12 **been completed 24 hours earlier by somebody else.**

13 Q. Yes. You may be right about that. But do you accept

14 that you did assess him as being suitable for rule 40

15 removal from association and filled in the form?

16 **A. I probably would have trusted what somebody said to me**

17 **and said, "Can you complete that?".**

18 Q. So you think that's someone else's assessment and not

19 yours?

20 **A. I would think so, I don't know. It's five years ago,**

21 **isn't it? I don't know.**

22 Q. In performing that assessment, did you review his

23 medical records for the purposes of filling that form

24 in?

25 **A. Don't know.**

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1 Q. If not, why not?

2 **A. I would assume that you trust the people you work with**

3 **and somebody has asked me to do that, so I've gone and**

4 **done it, same as I asked Mariola to complete the 213 for**

5 **me.**

6 Q. But it was important to know his recent history in

7 making that assessment, wasn't it?

8 **A. It would have been, but I would have assumed, as an**

9 **assumption, that somebody's asked me to complete it, so**

10 **I've just completed it.**

11 Q. As part of that assessment, suitable for rule 40 removal

12 from association, wouldn't the fact that he claimed to

13 be a victim of torture, and that a GP had agreed he may

14 be, be also relevant? That's a relevant factor, isn't

15 it, to his removal from association under rule 40?

16 **A. I don't know now. It's five years since I've worked**

17 **with any of these documents. I wouldn't know.**

18 Q. How would you generally carry out assessments that

19 someone was suitable for a rule 40 removal from

20 association at the time?

21 **A. Now, I don't know. As I say, it's five years since I've**

22 **done this.**

23 Q. Do you think you would have seen the detainee in person

24 in order to make the assessment, or would it be on other

25 information?

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41 (Pages 161 to 164)

<p>1 A. Maybe both. I don't know.</p> <p>2 Q. What was the purpose of the assessment for rule 40</p> <p>3 removal from association?</p> <p>4 A. As I say, it's five years ago. I haven't looked --</p> <p>5 worked with any of these documents. I couldn't tell</p> <p>6 you.</p> <p>7 Q. In relation to rule 35, and in particular rules 35(1)</p> <p>8 and (2), would you have been aware of those rules at the</p> <p>9 time in 2017?</p> <p>10 A. I would think so.</p> <p>11 Q. Do you think you had a full understanding of</p> <p>12 the different limbs of the rule?</p> <p>13 A. I would think so, yes.</p> <p>14 Q. You provided training in Brook House on torture</p> <p>15 awareness, didn't you, which included the need to refer</p> <p>16 for a rule 35 assessment?</p> <p>17 A. Mmm.</p> <p>18 Q. You provided that training as part of your documents to</p> <p>19 the NMC. Do you remember that?</p> <p>20 A. I don't think it was documents for the NMC.</p> <p>21 Q. They have an NMC -- we have certainly got them from the</p> <p>22 NMC. Perhaps we can look at them, <NMC000011> at</p> <p>23 page 6, please?</p> <p>24 A. I wouldn't have sent them to the NMC.</p> <p>25 Q. That may be right. They may have come from</p> <p style="text-align: right;">Page 165</p>	<p>1 A. Mmm-hmm.</p> <p>2 Q. Did you understand that, even if someone did have</p> <p>3 a rule 35(3) report as being maybe a victim of torture,</p> <p>4 that didn't preclude a report later being done under one</p> <p>5 of these limbs of the rule if the circumstances in them</p> <p>6 applied?</p> <p>7 A. Yes. Yes.</p> <p>8 Q. So you could have both, couldn't you: a rule 35(3)</p> <p>9 report and a rule 35(1) report if you were deteriorating</p> <p>10 in detention or a rule 35(2) report if you had suicidal</p> <p>11 intentions? You could have two types of report?</p> <p>12 A. I would think so.</p> <p>13 Q. It would be important that if someone was deteriorating</p> <p>14 in their mental health in detention, for a rule 35(1)</p> <p>15 report to be completed, or at least to be considered, by</p> <p>16 the GP; do you agree?</p> <p>17 A. Yes.</p> <p>18 Q. If there was a suspicion by anyone that someone had</p> <p>19 suicidal intentions, it would be important that</p> <p>20 a rule 35(2) report was completed, or at least</p> <p>21 considered, by a GP. Would you agree with that?</p> <p>22 A. Yes, but please remember I haven't looked at any of this</p> <p>23 since -- for five years.</p> <p>24 Q. Yes.</p> <p>25 A. So this is real memory.</p> <p style="text-align: right;">Page 167</p>
<p>1 Sandra Calver.</p> <p>2 A. Yes.</p> <p>3 Q. This has your name on it, "Torture awareness". Does</p> <p>4 that look familiar?</p> <p>5 A. I would have developed that, yes.</p> <p>6 Q. At page 20, please, that includes a reference to</p> <p>7 assessment under rule 35. Do you agree?</p> <p>8 A. Yes.</p> <p>9 Q. At page 21, next page on, you deal with rule 35(1):</p> <p>10 "Medical practitioner concludes that a person's</p> <p>11 health is likely to be injuriously affected by continued</p> <p>12 detention or any conditions of detention."</p> <p>13 Does that look familiar?</p> <p>14 A. Yes.</p> <p>15 Q. Over the page to 22, this is subsection (2):</p> <p>16 "To be completed if Dr has concerns that a detainee</p> <p>17 may have suicidal intentions and the detained person</p> <p>18 shall be placed under special observations for so long</p> <p>19 as those suspicions remain ..."</p> <p>20 That deals with the first two limbs of rule 35. Do</p> <p>21 you agree?</p> <p>22 A. Yes.</p> <p>23 Q. So it seems as though you were familiar with the</p> <p>24 separate limbs of the rule; indeed, you were training</p> <p>25 others on them. Is that right?</p> <p style="text-align: right;">Page 166</p>	<p>1 Q. I understand. But the purpose of the rule is to</p> <p>2 identify to the Home Office someone who -- there are</p> <p>3 suspicions that they have suicidal intentions. So</p> <p>4 that's the purpose of the rule 35(2) report?</p> <p>5 A. Yes.</p> <p>6 Q. If someone was deteriorating or was likely to</p> <p>7 deteriorate in detention, notifying that to the</p> <p>8 Home Office is the purpose of rule 35(1); is that right?</p> <p>9 A. Yes.</p> <p>10 Q. You would have understood that at the time, given you</p> <p>11 were working with these rules, and, indeed, providing</p> <p>12 training on them; yes?</p> <p>13 A. Yes.</p> <p>14 Q. They're important safeguards against the detention of</p> <p>15 vulnerable detainees. Would you agree?</p> <p>16 A. Yes.</p> <p>17 Q. A GP is the only person who is able to write the report.</p> <p>18 You would have been aware of that at the time, wouldn't</p> <p>19 you?</p> <p>20 A. Yes.</p> <p>21 Q. There was no doctor present during this incident on</p> <p>22 25 April, was there?</p> <p>23 A. No.</p> <p>24 Q. The mechanism by which a doctor becomes aware that</p> <p>25 a rule 35 report might be necessary is through a nurse</p> <p style="text-align: right;">Page 168</p>

<p>1 referral, isn't it?</p> <p>2 A. Not always. A doctor can refer and can do. It is not</p> <p>3 just a nurse that can do.</p> <p>4 Q. But if a doctor is not aware of something, they can't</p> <p>5 report on it, can they? They have to first become aware</p> <p>6 that one of the circumstances in limbs one or two of</p> <p>7 this rule is present, and how are they to become aware</p> <p>8 of it if they are not present during an incident of</p> <p>9 self-harm or suicide attempt? It is the nurse's</p> <p>10 obligation to bring it to their attention, isn't it?</p> <p>11 A. Yes, but I think here a doctor would have been aware of</p> <p>12 this man, having read his notes.</p> <p>13 Q. You certainly didn't refer this case --</p> <p>14 A. No, I didn't.</p> <p>15 Q. -- to a GP under rules 35(1) or (2), did you?</p> <p>16 A. No.</p> <p>17 Q. Why not?</p> <p>18 A. I'm assuming -- again, I don't know, but I'm assuming</p> <p>19 probably because he was under the care of the RMNs that</p> <p>20 they were looking after his needs.</p> <p>21 Q. There's no mention of the necessity for a GP to complete</p> <p>22 a rule 35 assessment in any of your documentation, is</p> <p>23 there?</p> <p>24 A. No.</p> <p>25 Q. In fact, the plan was just "Please review later this</p> <p style="text-align: center;">Page 169</p>	<p>1 you the absence --</p> <p>2 A. Not that I'm aware of. I don't know. I don't think so.</p> <p>3 MS SIMCOCK: Thank you. Chair, those are all the questions</p> <p>4 I have for this witness. Do you have any questions?</p> <p>5 Questions from THE CHAIR</p> <p>6 THE CHAIR: Thank you. I just have one brief question,</p> <p>7 Ms Buss. You talk about, in your statement, some of</p> <p>8 the conditions of working at Brook House, and you have</p> <p>9 obviously got a lengthy experience of having worked in</p> <p>10 other similar environments, both at Tinsley and in the</p> <p>11 Prison Service. Was Brook House different in any way to</p> <p>12 those other environments and, if so, how?</p> <p>13 A. Considerably different.</p> <p>14 THE CHAIR: Could you tell me a bit more about how?</p> <p>15 A. Tinsley House was very relaxed.</p> <p>16 THE CHAIR: I'm sorry, just so the transcriber can hear what</p> <p>17 you are saying --</p> <p>18 A. One or both.</p> <p>19 THE CHAIR: That's fine. If you just sit forward so she can</p> <p>20 hear.</p> <p>21 A. Tinsley House was quite relaxed and quite an open</p> <p>22 atmosphere where you could get to know your clients;</p> <p>23 smaller numbers. Brook House had very, very large</p> <p>24 numbers that you never knew and, again, even in</p> <p>25 comparison to the Prison Service, there was no structure</p> <p style="text-align: center;">Page 171</p>
<p>1 evening", wasn't it? That's inadequate, isn't it?</p> <p>2 A. No.</p> <p>3 Q. Shouldn't you, as the nurse present and monitoring this</p> <p>4 incident, have referred him to a GP for a rule 35(1) or</p> <p>5 rule 35(2) report?</p> <p>6 A. What about the other four nurses that were present at</p> <p>7 times through this?</p> <p>8 Q. Well, I'm asking questions of you.</p> <p>9 A. Yes, but other nurses were present, including an RMN.</p> <p>10 Q. Again, I'm asking questions of you. Why did you not</p> <p>11 make a referral to a GP under rules 35(1) or 35(2),</p> <p>12 given your understanding of the rule at the time?</p> <p>13 A. I don't know. I can't -- that, I can't tell you.</p> <p>14 Q. We know in 2017 there were only eight rule 35(1) reports</p> <p>15 completed and no rule 35(2) reports at all. Were you</p> <p>16 aware at the time that those numbers were so low?</p> <p>17 A. No. Wouldn't have involved us. We wouldn't have been</p> <p>18 told about things like that.</p> <p>19 Q. Were you referring detainees who had self-harmed or</p> <p>20 attempted suicide for rule 35 assessments?</p> <p>21 A. You refer them to the doctor for the rule 35 assessment.</p> <p>22 Q. Were you referring them?</p> <p>23 A. If I'd seen them, yes.</p> <p>24 Q. Did anyone ever raise with you the absence of reports</p> <p>25 under rule 35(1) or 35(2)? Did anyone ever raise with</p> <p style="text-align: center;">Page 170</p>	<p>1 at Brook House. You were trying to do a job in an</p> <p>2 incredibly difficult environment with varying levels of</p> <p>3 support. Some days it was there, some days it wasn't.</p> <p>4 It was an absolute hellhole to work in.</p> <p>5 THE CHAIR: You mention in your statement that you</p> <p>6 escalate -- "despite escalating the issue". Who did you</p> <p>7 escalate it to, can you remember?</p> <p>8 A. For?</p> <p>9 THE CHAIR: That you raised concerns about the environment</p> <p>10 at Brook House. Can you remember raising concerns with</p> <p>11 people?</p> <p>12 A. Not now. Not now. But I think, generally, you kind of</p> <p>13 know -- most people know it's not a nice place to be,</p> <p>14 and for detainees as well. It is not a nice place.</p> <p>15 THE CHAIR: Those are all the questions I have. Thank you</p> <p>16 very much. I know it is not an easy experience,</p> <p>17 Ms Buss, but I'm very grateful you have come today and</p> <p>18 I have listened carefully to your evidence.</p> <p>19 A. That's all right. Thank you very much.</p> <p>20 THE CHAIR: Thank you.</p> <p>21 MS SIMCOCK: Chair, before we finish for the afternoon,</p> <p>22 I neglected at the beginning of Theresa Schleicher's</p> <p>23 evidence to ask you to adduce both of her statements</p> <p>24 into evidence in full, they are <BHM000031> and</p> <p>25 <BHM000032>.</p> <p style="text-align: center;">Page 172</p>

1 THE CHAIR: I will do. Thank you.
 2 MS SIMCOCK: A slighter earlier finish. 10.00 am tomorrow.
 3 THE CHAIR: Thank you. Thank you, Ms Buss.
 4 (The witness withdrew)
 5 (3.49 pm)
 6 (The hearing was adjourned to
 7 Tuesday, 15 March 2022 at 10.00 am)
 8
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