Monday, 14 March 2022
(10.00 am)
(Proceedings delayed)
(10.14 am)
MS SIMCOCK: Chair, the first witness this morning is Dr Rachel Bingham.
DR RACHEL BINGHAM (affirmed)
Examination by MS SIMCOCK
MS SIMCOCK: Can you give your full name, please?
A. Dr Rachel Bingham.
Q. What are your qualifications?
A. I'm a GP. I obtained my qualification as a doctor in 2009 from King's College London School of Medicine, from where I also had a Masters in Philosophy of Mental Disorder. I went on to complete my training as a GP at University College Hospital London, getting my MRCGP or Member of the Royal College of General Practitioners, in 2015. Alongside my training as a GP, I have developed my interest in the medical care of asylum seekers and refugees through training at Freedom from Torture and Medical Justice in assessment of survivors of torture and ill-treatment using the Istanbul Protocol, and I have supported that with diplomas in medical care of conflict and catastrophe, forensic medical science and in public health.

Q. Your role is the clinical advisor to Medical Justice; is that right? What does that role entail?
A. That's right. As clinical advisor, I provide clinical technical support to our team of caseworkers, for example, answering medical queries or looking at medical records in our cases. I do casework myself, seeing clients and writing medico-legal reports, doing medical assessments, and I provide support and training to our network of about 65 volunteer doctors.
Q. In a nutshell, what does Medical Justice do as an organisation?
A. Medical Justice provides support and help to people who have medical problems in immigration detention or have medical needs, including a need for medical evidence in their asylum case and, as an organisation, Medical Justice provides clinical evidence and case work and policy work relating to immigration detention.
Q. Medical Justice has a number of volunteer doctors. You say in your statement they are mostly GPs. But do they also comprise other disciplines as well?
A. Yes, that's right. They are mostly GPs, but we have doctors from a range of specialties, from surgical, medical specialties and a number of mental health specialists, psychiatrists and psychologists.
Q. You say that they have to have a certain amount of

experience to be able to volunteer for Medical Justice. Just explain that?
A. So for medical doctors, we require them to be three years post their foundation training, so that's five years post qualification. For GPs, that normally means qualification as a GP or equivalent relevant clinical experience.
Q. Medical Justice provides training for the role of volunteer doctor. Just summarise what that training involves for me?
A. So we do a basic training, which is some home or remote learning to work through some modules in assessment of mental health in detention, assessment of scarring, and in self-care, and then we support that with a face-to-face, one-day training which goes back over those topics, introduces people to some of the legal aspects and policy aspects of immigration detention, and then focuses on medical aspects of assessment of people in detention. That's our basic training. And then, having done that, we pair up new volunteer doctors with experienced doctors to observe assessments taking place, and they do that as much as they need to, depending on their prior experience and expertise, before perhaps doing a joint or observed assessment with an experienced doctor. Again, until they feel confident and competent

to be able to do that role themselves.
Q. There is a particular process for the completion of medico-legal reports at Medical Justice. Again, just summarise what that is for me?
A. That's right. So the medico-legal report is done in, normally, a face-to-face or, since Covid, sometimes an online consultation between the doctor and the client. That's usually at least a 90-minute assessment. If there is a need for interpreting or a longer assessment, it could be several hours of a one-to-one assessment of -- if it is a general GP, it might be an assessment of their mental health and of any scarring. After that, the doctor writes a report which details their clinical findings, reviews the person's medical documents, looks at, for example, immigration detention centre medical records in detail, and, putting all that together, forms their opinion, and the questions they would likely cover would be about the consistency of the presentation with the person's account. So the extent to which the findings are evidence of torture or ill-treatment that the person has reported in their asylum case.
There might be other questions they would cover too, but often focus on that. Having produced their report in draft, that report goes to a caseworker and a clinical reviewer, who is an experienced doctor, for

a clinical review, which is a peer review, really, but by an experienced clinician. We have a small team, just six experienced doctors, who read all of the reports at that stage so that helps us to provide some quality assurance and ensure a consistent standard for our reports.

Then, after that, the report would be finalised with the doctor.

Q. For the purposes of giving evidence to the inquiry, you prepared a statement, and it is at <BHM000033>. I am going to take you to some parts of that statement and, in particular, to the case studies that you have analysed in preparing that statement. I am not going to take you to absolutely everything in it, because I will ask that the statement in its entirety is adduced into evidence. What that means is that it stands as your evidence, so I don't need to ask you about every single line in it.

In relation to the case studies you have looked at, you have been able to analyse those and identify various themes arising out of them. How many case studies did you look at?

A. Sorry, I don't have the answer off the top of my head, but at least 90 rule 35 reports plus the six detailed case studies I have appended to my statement.

Q. I want to look at, then, various of the themes that came out of those case studies that you deal with in your witness statement. The first one you identify is a failure to recognise symptoms of mental health problems in IRCs. In particular, you refer to PTSD and depressive disorders. At paragraph 61(b) of your statement, which is at pages 21 and 22 -- your statement should be in the bundle in front of you at tab 1, if you need to refer to it.

A. Thank you.

Q. You look at the case of D1525 and, again, you should have a cipher list in front of you. We are referring to the detained persons by their D number --

A. Yes.

Q. -- and not their name, and for reasons that will be obvious to you. D1525 disclosed to a nurse that he had been kidnapped, beaten and had scars on his back and arm and that he suffered flashbacks, and a rule 35 assessment carried out subsequent to this disclosure documented his account of torture and trauma-related symptoms of flashbacks, anxiety and fear. Although the GP concluded that D1525 may be a victim of torture, he didn't make any comment on D1525's mental health, even though there were those apparent trauma-related symptoms present. He was seen by a mental health nurse who

subsequently assessed him, but also didn't explore those symptoms further, and he was under the care of the mental health team for two months, but no-one from healthcare undertook any specific investigation into his trauma symptoms. He was then referred to Medical Justice. He was diagnosed by one of your psychiatrists to have PTSD and to have been adversely affected by his detention and, following that report being produced by Medical Justice, he was granted bail.

What sort of failures do you consider that this case illustrates?

A. Thank you. I think this case is a fairly typical example of the types of failures that we have been highlighting. So starting with the rule 35 assessment, which, as you say, was an assessment to document his history of torture and any associated features, in this case, the individual has said that he has flashbacks and fear in episodes, and the doctor has noted that these are not very often and the person is saying they manage them themselves. They have gone on to conclude he's been referred to the mental health team, and the only mention of mental health issues in the concluding sections of the report, which is essentially the summary of the advice to the Home Office about the person's condition, just says "some low mood" and referred to the

mental health team. So the implication is, this person can be managed in detention.

But, actually, looking at the bigger picture, we have got somebody who has given a history of torture and is now giving a clinically plausible account of flashbacks and episodes of fear which are clearly features of PTSD, so they're clearly symptoms related to a history of torture. So that should be recognised and flagged up. Why is that particularly relevant here? Well, because a person who has given an account of torture is now in detention, which is an environment that is known to trigger and exacerbate exactly these types of symptoms. So these are the most relevant symptoms to identify in this context. What does it mean to miss that? Well, it means leaving the person in a situation where those symptoms will be exacerbated, and that's really a source of extreme distress and suffering, because flashbacks being exacerbated, it's not just a symptom that, you know, happens in passing. That's a reexperiencing of torture. So what's happening in the person's experience there is going to be as if they are being tortured again. So it's really important, from a clinical perspective, that a risk of that symptom being exacerbated, which we know to be a risk in this environment, is picked up and flagged up,

but was missed in this case. As in many cases we continue to see, this person then went on to stay in detention until one of the Medical Justice doctors picked up and diagnosed the PTSD, and we can see that that did lead to the person being released.

Q. To his release?

A. Yes.

Q. Do you have a view as to the reasons for these types of failures occurring, particularly given that the rule 35 forms themselves direct consideration of mental health symptoms, don't they?

A. Yes, that's right. One of the questions in the final section is to specifically consider if there's a risk of deterioration in that environment and one of the other questions is to highlight psychological consequences of the ill-treatment the person describes. So there is the direction there in the form, and yet we repeatedly see that that is missed. The reasons, I think, for missing this safeguard, it's not, therefore, that there's a lack of clarity in the form that needs to be filled in, but it's that it's not done. So to answer that question, I think we need to look at a bigger picture of systemic failures to implement these safeguards and to fully understand their importance.

Q. Would training help?

A. I think training is important, but, as I say, the information is there. So we think that there are systemic failures in a bigger picture of why these things are not being implemented. I think, as has been described elsewhere, the clinicians are working in an environment which is not conducive to recognition of the symptoms. First of all, there needs to be a disclosure, so the clinicians need to be perceived as independent and able to advocate for the patients, and then, when there's a disclosure, that needs to be recognised and acted on by the clinicians. But, actually, we think that there are many systemic and environmental factors that mean that those steps don't happen.

Q. I want to look at the case of D1527 next, please, and your statement comments that this case illustrates a number of different concerns or failures in the system. We are relatively familiar with the case of D1527 now, given the evidence to the inquiry. His medical records contained multiple indications that he was at risk of suicide. On arrival at Brook House, he was already on an ACDT. He had a past history of suicide attempts. You say that that's a strong predictor of future risk; is that right?

A. Absolutely, yes.

Q. He also had a past history of self-harm and ongoing self-harm, which you say also increases the risk of suicide. So not just previous suicide attempts, but other acts of self-harm are also an indication of a high risk of suicide?

A. Absolutely, yes.

Q. He expressed hopelessness and possible auditory hallucinations. In addition, he was recorded to state suicidal intent. So he was making a disclosure that he intended to commit suicide. None of this information appeared to have been drawn together by anyone, you comment, in healthcare to recognise and communicate that he was someone at high risk of harm and deterioration in detention. The relevant mechanism for managing risk of self-harm and suicide appears to be the ACDT. Would you agree with that?

A. I think ACDT is what's used to manage these risks, yes.

Q. What is the problem with the ACDT system in management of self-harm and risk of suicide?

A. So ACDT is not a clinical -- it is not a clinical tool. So it is not a therapeutic or a clinical response. It is more of a management response for behaviours that are problematic and difficult to manage in a secure environment. So it doesn't address at all the underlying causes. It doesn't provide any sort of

treatment or therapeutic intervention to alleviate the person's distress or to improve the symptoms of their mental health.

Q. So is it an adequate response to the risks presented by someone who's presenting with self-harm or suicidal intent?

A. No, I think, for those reasons, it's an entirely inadequate response. I would also refer to Dr Brodie Paterson's statement, who has explained that ACDT is a prison-style response, not at all suited to clinical presentations in immigration detention. Because it doesn't address the underlying psychological symptoms, because it doesn't relieve distress and because it doesn't provide any therapeutic input, it is not only an inadequate response to those things, it is just not a response to them.

Q. It also doesn't appear to either automatically, or through any particular process, trigger the consideration of rule 35, does it?

A. No. There's no automatic triggering of rule 35, and I think that's very clear from the lack of rule 35(1) and (2) reports.

Q. Is that also a significant concern in relation to the management of those with self-harm and suicidal intent?

A. Absolutely. I mean, the absence of rule 35(2) reports

means that suicidal intent was never communicated to the detaining authority in a way that triggered a review of the suitability of that person for detention, so that safeguard is entirely absent.

Q. That's a significant concern, clearly. It seems still currently to be the case; is that right? Is that your experience?

A. That's absolutely right. I haven't seen any rule 35(2) reports since the period of the inquiry.

Q. You also say in relation to D1527's case at paragraph 160 of your statement that it demonstrates the use of segregation as an indirect and inappropriate means of managing his distress, symptoms of mental health problems and self-harm. Is that right?

A. Yeah, that's absolutely right. Segregation is an example of what the security staff have recourse to in the absence of mental health training and in the absence of an understanding of an appropriate clinical -- they are not clinical staff, and in the absence of an appropriate clinical response to people at risk of self-harm who are distressed or who are difficult to manage, people are moved to segregation. So that's very concerning for us. That's particularly concerning because segregation and isolation are factors that actually exacerbate mental health problems, cause

deterioration in many mental health conditions, and are associated with increased thoughts of self-harm and thoughts of suicide, related to the environment and segregation and related to social isolation, and so what looks like a response to manage the behaviour actually exacerbates the behaviour and the symptoms and, therefore, that can lead to a cycle in which the person's distress becomes worse and the response becomes stronger, whereas, actually, what is needed is a de-escalation and a therapeutic intervention.

Q. In your view, healthcare staff should have been raising contraindications, reasons not to use segregation in D1527's case; is that right? Who should have been raising those particular concerns?

A. So the person in D1527 was seen by mental health nurses, by nurses and by the GPs, and all of them had the ability to raise concerns. Only the GP was able to do a rule 35(1) report to report the person as at risk and as deteriorating in detention. So it was important for the other professionals to raise their concerns to the GP and for the GP to then escalate those concerns and communicate as a safeguarding mechanism to prevent further harm.

Q. So, in your view, a rule 35(1) report should have been completed in his case?

A. Yes.

Q. And, indeed, a rule 35(2)?

A. 35(2), yes.

Q. You also say that D1527's case illustrates the use of force and restraint on vulnerable detainees and used as a potentially harmful and inappropriate tool to manage mental health problems and expressions of distress. At paragraph 142 of your statement, you discuss the incident on 25 April with Yan Paschali that we are all very familiar with. You say particularly that the entry in the medical records omits all reference to the assault or injuries which should have been documented by the medical team. Why is it important to accurately record a use of force in the medical records, in your view?

A. It is the duty of any healthcare professional. It is very clear in the Nursing & Midwifery Council Guidelines as in the General Medical Council Guidelines that, as professionals, we have to document what has happened, what we have done and what our patients have told us, and this was clearly, however else it is looked at, a very significant event which the nurse was party to. So she absolutely had to write down a record for posterity of what had happened and her involvement and the impact that she observed on her patient. In this

case, clearly, there was a serious safeguarding concern to be reported, so that would just add to it. But, in any event, it should have been documented.

Q. He didn't appear to receive an examination of his mental state after the incident. Is that right?

A. No, that's absolutely right, and I think that perhaps follows from the failure to document and communicate it within the team. The implication of it not being in the notes is that people later wouldn't know about it and, therefore, care wouldn't be provided.

Q. Have you looked at the note that was recorded in the medical records by Nurse Joanne Buss?

A. Yes, but I think you'll have to remind me.

Q. I can certainly do that. It is <CJS001002>, please, at page 38. Just scroll down slightly, please. There is the entry on 25 April at 18:51 by Staff Nurse Joanne Buss:

"Placed on rule 40 constant supervision as he refused to return to E wing. Called to E wing at approx 1900. Constant watch. Had placed a ligature around his neck. Removed by staff. Staff trying to engage with him. RMN Dallah tried to engage with him with minimal effect. Put mobile phone battery in his mouth which he later removed battery removed from his room. Went to toilet and attempted to self-strangulate. Angry and not

engaging with staff. Hands removed from his neck by staff. Salivating + +. Unable to take any observations. Visual obs resps 16."

Respiratory rate 16; is that right?

A. Yes.

Q. "Slight redness noted on his neck. 20:00 got up and walked around room. Taken a small drink. Restless. Constant watch continues. Not engaging with staff. Plan: please review later this evening."

Does that adequately record what we have all now seen several times in the footage?

A. What we have seen in the footage is a clearly very dangerous act by a member of the security staff putting his hands on the person's throat, and so I don't think that is recorded at all or any intervention or response to it. So I don't think this reflects what I have seen in the footage at all.

Q. Even leaving aside the particular, as it has been called, "choke hold" applied by Yan Paschali, does "Had placed a ligature around his neck. Removed by staff" adequately record the use of force upon D1527, even leaving aside the choke hold?

A. No, I don't think so, no. I think there's much more explanation of what happened. I can appreciate the nursing notes would be brief, but this is a very serious

incident that you would expect somebody to record in detail.

Q. Does "angry and not engaging with staff" really cover accurately the presentation D1527 had in really quite severe mental health -- a mental health episode and distress?

A. I think this is an example of the sort of way that mental health symptoms can be reinterpreted as behavioural symptoms. We know that this is a person with post-traumatic stress disorder who would likely be very frightened in this type of threatening situation that he would inevitably perceive as threatening, and so this use of this type of terminology "angry and not engaging", it really misses the more clinical observations that I would expect clinical staff to be able to make about levels of anxiety and distress and mental health symptoms.

Q. Yes.

A. So I think "angry and not engaging" doesn't really capture the clinical presentation.

Q. It is not accurate?

A. No.

Q. I'd like to move on then, please, to D13. You say in relation to this case that, in relation to food and fluid refusal, a fundamental part of the problem is that

the underlying causes of food and fluid refusal are not routinely explored. Is that your experience in relation to detainees who are refusing food and fluids?

A. Yes, absolutely. Quite often, the only documentation is just refusing food or refusing fluids, but the reasons why are many. So we often see people who are in detention who have lost their appetite because of their mental health symptoms or we see people who have paranoid beliefs about the detention environment refusing food for that reason. It's correct that sometimes people are also protesting their treatment and the one thing they have recourse to is to refuse food. But I don't think we can assume -- especially as clinicians, it's really important not to assume that the reason is a protest or a disruptive behaviour without exploring --

Q. Did that seem to be --

A. Absolutely.

Q. That seemed to be the assumption, that it was simply a protest, a conscious choice?

A. Yes.

Q. And not as a result of underlying mental ill-health or distress at being in detention?

A. No, absolutely. I think that type of assumption we see often and we continue to see.

Q. Food and fluid refusal didn't seem routinely to lead to consideration of rule 35(1) or, indeed, rule 35(2) reports. Was that your experience?

A. Yes, and that clearly follows from a failure to look for and understand the root causes of the food and fluid refusal.

Q. In your view, had it been appropriately considered, should there have been likely more rule 35(1) and, indeed, rule 35(2) reports in relation to some detainees who were refusing food and fluids?

A. Yes, that's right. Because, for example, in the cases I mentioned where somebody has lost their appetite through their mental health or where somebody has developed paranoid beliefs, often that is a consequence of the mental health deterioration in the detained environment and clearly that fits into rule 35(1), particularly now if the person is not eating or drinking, their physical health is at risk as well. So it would be really important to communicate.

Q. You have also said that it's necessary to consider an assessment of mental capacity when someone refuses food and fluids. Was that routinely happening, in your experience?

A. No, I don't think that was routinely happening, no.

Q. Should it have been?

A. Yes. So especially at the point where somebody's health or physical health is impacted by refusal of food or fluids, a mental capacity adjustment is essential. It is part of Department of Health guidance for how to manage food and fluids -- people who are refusing food or fluids so it is something I would expect healthcare staff to be aware of, but we see that that very often does not happen.

Q. You say often detainees were put on an ACDT who were refusing food and fluids. That was the case, indeed, with D1527. Was that an appropriate response or adequate management of what perhaps were underlying reasons for food and fluid refusal?

A. No, as I have said about ACDT, that's not a clinical response, so that's just a behavioural management response from the security staff. So that doesn't necessarily involve healthcare and it doesn't trigger any of the safeguards like rule 35 that were so important in this case. It definitely doesn't trigger a mental capacity assessment. So it doesn't lead to any clinical protection of that person.

Q. You say that ACDT has become, or is, indeed, disconnected from the Adults at Risk framework. Should the Adults at Risk framework come into play in relation to food and fluid refusal?

A. Yes. If the person is properly assessed and their mental and physical health are assessed, and then, if they're found to be, as in the cases I've mentioned, refusing food and fluid as a result of mental health issues or as a result of deterioration in detention, then that absolutely should trigger the Adults at Risk policy.

Q. So if we look at D13 then. It is at paragraph 79(b) at page 28 of your statement. This is someone who intermittently stopped eating for various short periods throughout his detention at Brook House. There was a delay in identifying several episodes of food refusal and triggering the food and fluid refusal monitoring process, with observations belatedly imposed only several days after D13 had stopped eating. Just dealing with those observations, they tended to just be physical observations; was that your experience?

A. Yes, absolutely. So the person might get their blood pressure recorded if they agreed, but there is very rarely an exploration of their mental health.

Q. D13 was open to the mental health team throughout and subject to an ACDT for an overlapping period on account of his suicidal ideation. But you say there was no substantive assessment of the motivation for his food refusal or the potential interplay with an exacerbating

effect on his mental vulnerabilities and risk to himself. Should a rule 35(1) report have been considered in his case?

A. Yes, absolutely. So that goes both ways. His mental health feeds into why he might be refusing food and fluid. And food and fluid refusal, if it is prolonged or repeated, may also have a detrimental effect on his mental health. So it needed to be considered as a whole picture.

Q. And indeed, there should have been consideration of a rule 35(2) report given overlapping suicidal ideation?

A. Yes, and as he was required to be on ACDT for a long time, it shows he was considered to present an active risk, but that safeguard was just not implemented.

Q. Looking briefly at the assessment of mental capacity, you look at the case of D1275 at paragraphs 81 to 96 of your statement, and you say, in relation to -- sorry, paragraph 93. In relation to the assessment of mental capacity of detainees, the approach in D1275's case exposes the detriment to a vulnerable detainee caused by the absence of a structured process by which concerns about a detainee's mental capacity are raised, investigated by whom, or guidance on what action should be considered thereafter. There wasn't a structured process. Was there any process for identifying issues

about mental capacity?

A. No, this is a really difficult case of a person who became very mentally unwell and lost mental capacity, but I think the failures in this case are illustrative of failures we are seeing in the bigger picture. In this case, perhaps he was identified as somebody about whom there should be concerns because he was repeatedly booked in to see mental health staff. So this is a person who actually missed 13 appointments with the mental health team. On three occasions, he was discharged from the mental health caseload and the missed appointments, unfortunately, are summarised in the medical records as a number of hours used up or wasted, if you like, rather than identifying that loss of appointments as a concern in itself: why did he keep being booked in for mental health appointments and not turning up should be an indicator that there's something going on, requiring more assessment. And in this case, those concerns are actually flagged up by the security staff. So security staff have asked for appointments with healthcare. At one point, security staff have raised the question of whether he has capacity to attend those appointments.

Q. Yes. But none of that was followed up?

A. But none of it was followed up. On one occasion,

a nurse attended the wing but didn't manage to speak to him and then nothing else happened afterwards. So there is enough -- looking at the notes now, there is enough information to see that there are concerns, but because there was no attempt to engage him, there was no message sent to him, there was no further telephone call to him, there was no further trip to the wing to try to find him, but because he wasn't engaged, he wasn't properly assessed, and his mental capacity concerns were not identified. In this case, that leads, as in other cases, to just a documented deterioration in his mental health. We don't -- of course we don't know what would have happened if his mental capacity had been identified earlier, but we know that he was in detention for over a year without that being identified, and sadly, after release, he was so unwell that quite soon after release he was admitted under the Mental Health Act to a psychiatric hospital under a section. So he was a person whose health was really harmed by that process.

Q. He was assessed to have bipolar affective disorder or a psychotic illness and that he lacked capacity --

A. Yes.

Q. -- but only after he was released from detention after a considerable period of time, as you say?

A. Yes.

Q. There was no rule 35(1) or any type of rule 35 report in his case?

A. No, exactly. And that's particularly important in this case because, if the detention centre staff couldn't assess him, they couldn't be assured of his safety and they should have communicated his risk if he couldn't be managed -- you know, in detention, there is no choice about which healthcare team to see. In the community, there are a choice of practices, other people the person might see, advocacy or support structures the person would normally use. But he didn't have that choice. There was only the healthcare team there. So if they were not able to assess him, they should have communicated that they couldn't manage him to the Home Office. But, actually, I think what this case highlights is a failure to follow through on that assessment.

Q. He simply slipped through the net?

A. Yes.

Q. In relation to rule 35, I just want to look at some aspects of the rule 34 and rule 35 process. You were here on Friday to hear the evidence of Dr Oozeerally and Dr Chaudhary, I believe?

A. Most of it, yes.

Q. Dr Oozeerally gave evidence of a practice in relation to

rule 35 reports not being written, or indeed considered, at the rule 34 GP assessment that's required within 24 hours of arrival at an IRC. Do you remember that?

A. Yes.

Q. But the practice being that a second assessment appointment was booked if something was flagged initially through screening or in that appointment, sometimes booked after, indeed, a considerable delay. Do you have any comment upon that practice that appears to still be ongoing?

A. Yes. I think the practice is still ongoing. What we see in the initial GP appointment doesn't seem to fulfil a rule 40 appointment. What we see tends to be an assessment of immediate health needs in detention. So usually limited to prescription of medication for long-term conditions. It's not a systematic assessment of the person's risks in detention. So it doesn't include a detailed assessment of their mental health, of their physical health, other than those perhaps medication needs that have been flagged up. And it doesn't identify people that might, for example, be survivors of torture. So it doesn't feed in -- it can't feed into the rule 35 process automatically because there isn't enough detailed assessment. We heard from the doctor that even where those risks were flagged up,

they weren't reported straight away because a further appointment was booked later down the line.

Q. So leading to delays?

A. Absolutely.

Q. So the safeguard under rule 34 isn't operating as a safeguard in identifying vulnerability at the outset of detention; is that your view?

A. No, it's not, no.

Q. In relation to D1525, you say here -- this is in relation to rule 35 -- the doctor noted repeated and sustained beating by other villagers on account of his sexuality which the police did nothing to stop. The doctor documented various prominent scars and noted flashbacks and anxieties but concluded that the incidents of ill-treatment were more of an Adult at Risk -- more an issue of an Adult at Risk. You say it is concerning that the risk to D1525 of being in detention was not further explored. In your view, was there an adequate understanding amongst healthcare staff, including GPs, concerning the definition of torture and the purpose of rule 35(3) as a safeguard?

A. So to take those two points separately, in terms of the definition of torture, as my colleague Theresa Schleicher has explained in her witness statement, there was a potted history with the

Home Office where the definition had been changed. It is not clear in this period in 2017 how clear the doctors were about what the definition was. In this case, the rule 35 report includes the old definition, which includes that the torture route was authorised by the state. So you can see that that's fed into the doctor's conclusion there and to say "more of an issue of Adult at Risk", but the doctor has missed that the clinical point -- actually, his assessment doesn't have to be a legal assessment. He's not being asked to decide whether or not the person should be a survivor of torture. He's being asked to document the psychological and physical consequences and the impact of detention on that person. And so I think whether or not the person was a survivor of torture has perhaps distracted the doctor from documenting what he should have focused on, which was the risk of harm to that person in detention.

Q. Being an Adult at Risk doesn't preclude a rule 35(3) report. Indeed, it's the opposite, isn't it? It should prompt consideration of it?

A. Well, exactly. I mean, it's the Adults at Risk policy, so he needed to communicate why that person was an Adult at Risk which he clearly thinks they are.

Q. You refer at paragraph 103 of your statement to research and literature in the public domain that someone who has

suffered a past history of torture would be at risk of harm in detention. Is that right?

A. Yes, that's right.

Q. You say that, in the medical community you work in, IRCs, it's well known that that's the case, that simply having a past history of torture or trauma involves a risk of harm in detention?

A. Yes. So I don't think it's possible to escape that information, really, because it's the kind of unanimous professional consensus if you look at research into mental health in immigration detention. For example, a meta analysis looking at all the recent studies of mental health in immigration detention. The von Werthern study in 2018 reported that all the adult studies showed an association between immigration detention and detrimental impact on mental health. So it's not that there's kind of conflicting literature to find.

As GPs, of course, this is a specialist field, and I understand, of course, not all of us work with asylum seeker/refugee populations, but --

Q. But those who work in IRCs definitely do?

A. Exactly, and our duties, as a doctor, is to keep ourselves abreast of information and guidelines which are relevant to our work, not to other types of work as

a GP. So in this sector, we are responsible to be aware of the latest professional guidelines, by which I would include the successive statements by the Royal College of Psychiatrists, because they relate to the mental health care of people with mental disorders in immigration detention, which clearly the healthcare team are responsible for, and now there's NICE guidance about PTSD, which was in existence from 2005, they should be aware of, and now there's guidance from the Faculty of Forensic and Legal Medicine about care for survivors of torture in detention.

Q. Dr Oozeerally didn't seem to be aware of any of that. Is that acceptable in your view?

A. No, I think it's unacceptable, and I find it surprising that, being a senior, experienced GP leading others in that sector, that he wouldn't not only know about it, but be trying to disseminate that information to his colleagues and proactively look for it.

Q. You heard his evidence about how he applied the likelihood of harm assessment in relation to victims of torture. Do you think he really had any understanding of the safeguards under the rules in relation to the type of assessment he was meant to be undertaking?

A. No, I think that there was a lack of understanding about the rules. That fits, really, with our experience. So

rule 35(3) reports tend to be done, albeit with the problems that I have described in my witness statement with them, but we know from Dr Oozeerally's evidence and from the other evidence that rule 35(1) was very rarely done and rule 35(2) was never done, and so, you know, we have heard from them that they were just not doing -- not participating in that safeguard, which is clearly a policy that applies to their work and clearly a very important part of safeguarding because that's the only mechanism by which the detention of people identified as Adults at Risk will be reviewed by the Home Office.

Q. In relation to a failure to address mental health aspects in rule 35 reports and, indeed, a failure to assess the impact of detention, you looked at the case of D2442 at paragraph 110 of your statement. This detainee gave an account of torture under the mental health section of the report. It was noted that he had been started on some medication due to low mood and thoughts of ending his life. He was also noted to be under the care of the mental health team. He had tried to hang himself two days before the rule 35 assessment. Yet, despite that, and despite what were clear and obvious reported symptoms, indicators of risk, it appears the opinion of the doctor's colleague that medication was required, the doctor concluded there was

no evidence of severe mental health issues and, therefore, didn't go on to consider the impact of detention.

In your view, is the conclusion "no evidence of severe mental health issues" justified in this particular case?

A. No, so this is a typical example where a phrase like "no evidence of severe mental health issues" is put in a context where it's then to be interpreted by a non-medical reader and allows clearly for the interpretation that there was no risk of harm to that person in detention. In fact, this person has made a very recent suicide attempt, is under care of the mental health team and is on medication. So there definitely are mental health issues.

Q. There are mental health issues.

A. But that's not communicated. I think one of the reasons for that may be a use of severe mental health issues to refer to psychotic mental illness, and, clinically, perhaps, that's a category that's recognisable and it makes sense, but it doesn't mean -- it doesn't relate to the severity. So somebody could have PTSD or depression, but not have that category of mental health issue, so they are not psychotic, but they still have severe mental health issues and are at risk in

detention. I think that's the case in this case. But the communication is unclear and the risk is not communicated and so that safeguard, again, fails.

Q. Yes. Again, Dr Oozeerally confirmed in his live evidence, as indeed did Dr Chaudhary, that they are still not completing reports under rule 35(2), and indeed Sandra Calver confirmed and, indeed, very few under 35(1). That still remains a significant concern, doesn't it?

A. Absolutely. I'm as concerned now as I would have been then that these safeguards just don't operate despite an ongoing, very high prevalence of these types of mental health issues in people in immigration detention.

Q. The concern in relation to rule 35(3) reports is that frequently, as in D442's case, where there's a failure to consider the impact of detention on him, even though the form directs it, there is then a reliance by the Home Office upon that lack of consideration in maintaining detention, in cases where potentially there shouldn't have been; is that right?

A. Yes, absolutely. So the rule 35(3), as we see repeatedly, the doctor is quoted and cited in decisions to maintain detention. It will say, "The doctor has not identified any harm to your health in detention", so we know how important that is. We don't know, and I don't

think there is any sort of further safety net where that decision is fed back to the doctor and the doctor should then review -- see the person again. If they were at risk of harm in detention and they are still in detention, they should be specifically reviewed to see what's happened to them since.

Q. There seems to be no system at all for ongoing review?

A. There is no system for that.

Q. A significant number of rule 35(3) reports from the period, but indeed likely ongoing, continue to fail to identify the impact of detention upon a detainee at the point where the rule 35(3) report is done?

A. Yes, that's usually not considered, yes.

Q. In relation to the use of Part C forms, there was some evidence given by both Dr Oozeerally and Dr Chaudhary on Friday that they used the Part C form to inform the Home Office of a deterioration in a detainee's health instead of, or potentially in addition to, rule 35, which Dr O referred to as a weighty document. In other words, that a rule 35 report was a weighty document. Do you agree that it is a weighty document?

A. I know -- I mean, as a GP, I can relate to being busy and not wanting to duplicate efforts, but I don't think in this case it's very difficult. They can have a technology to copy and paste their findings into the

same report and I'm sure if they understand the importance of this safeguard, it would be clear that that's what needs to happen.

I note the same people have not raised concerns that they didn't have time to safely do their work, and I think that's the pathway. If you don't have time to follow safeguarding procedure, then you surely need to raise concerns that you don't have time to do your work.

Q. I'm summarising, but the evidence that Dr Oozeerally gave for the reasons for using Part C instead of rule 35 reports was that it was a more dynamic way of informing the Home Office of concerns. They would get a response quicker. And, in his experience, the receipt of a Part C would lead the Home Office to review detention and, indeed, release detainees, even though there's no statutory requirement for the Home Office to have done so. Is that your experience of the use of Part C?

A. No, it's not, no, because we see cases where there are Part Cs in the notes and detention has not been reviewed and the person stays in detention, but we also see cases where there is no Part C and no concerns raised. But, in any case, the important point is that, what's actually a safeguard is something that requires a response. So this is the same in all of our safeguarding training for safeguarding adults and

children: there needs to be a process which triggers a response and can then be reviewed. Part C doesn't require a response, it doesn't require a review of the detention by the Home Office. So it's not a safeguard. It might be a communication in the best case scenario that they are saying happened sometimes, but it doesn't trigger a review of detention, so it is not a safeguard.

Q. In relation to Part Cs, they are also more general than just a concern about a detainee's health or risk, aren't they? They can be about a number of other different things. So it is not focused upon vulnerability in the same way that rule 35 is?

A. No, that's right. It's not part of the Adults at Risk policy as a safeguard to flag up those safeguarding vulnerabilities. So it's not a safeguard, that's right.

Q. In relation to D801, then, he had four Part Cs completed in relation to him and sent to the Home Office. He had arrived in Brook House on 1 March 2017. His screening by a nurse indicated a diagnosis of PTSD and a history of torture. An ACDT was opened due to an increased risk of self-harm, but no rule 35(3) report was done at that time and, indeed, no rule 35 assessment appointment was booked for him; is that right?

A. No, thank you, and thank you for summarising. I think

that's a clear example of repeated Part Cs not triggering a review of detention.

Q. If we look at just the chronology of the Part Cs and what was happening when each one was raised, he didn't attend his routine rule 34 assessment that was booked for him on 1 March. That was with a GP. That was the day he arrived. But he did see Dr Belda, who was a psychiatrist, on 2 March, who noted:

"He is experiencing flashbacks, overwhelming anxiety and high emotional arousal, insomnia, nightmares and severely low startle reaction."

He also noted he was very distressed during the appointment. A Part C had been completed in relation to D801 on 1 March, but he was maintained in detention after that. The plan Dr Belda had on 2 March was to transfer him to hospital under section 48 of the Mental Health Act. Does that indicate that Dr Belda thought he was very unwell, he needed inpatient psychiatric treatment?

A. Yes, that's right.

Q. At that stage, at 2 March, with that assessment, there should have been a rule 35(3) and, indeed, a rule 35(1) report, shouldn't there?

A. Yes, absolutely. They clearly identified a person who couldn't be managed in detention who required

a different type of treatment who was at risk of harm in detention because of the symptoms you read there that are characteristic symptoms of trauma-related mental disorder.

Q. He was also the subject of a Part C completed by Sandra Calver that I asked her about when she gave her evidence, and he was noted on that Part C to be an Adult at Risk at level either 2 or 3. At that stage, again, no rule 35 report completed. Again, there should have been, shouldn't there?

A. Yes, yes.

Q. And he was maintained in detention after the Part C on 13 March. On 19 March, it is noted in the medical records that the previous day he had applied a ligature, so a serious episode of self-harm, potentially a suicide attempt. Would you agree?

A. Yes, absolutely, yes.

Q. And, again, a Part C was completed on 19 March to notify the Home Office of the ligature. Again, he was maintained in detention after that Part C was sent to the Home Office. Again, at that stage, a rule 35(1) and/or a rule 35(2) report should have been completed, shouldn't it?

A. Absolutely. So the rule 35(1) should have been done already and certainly could have been done again.

Rule 35(2), because suicidal intent has been demonstrated by a very serious suicide attempt, unfortunately.

Q. And he, again, remained in detention. A note on 31 March in his medical records prompting the last Part C in relation to him recorded by Dallah Dowd that he wasn't fit to be in Brook House, he was unfit for detention, he should be released on health grounds, that he needed specific trauma therapy which cannot be provided at Brook House, and there had been no change in his clinical presentation to previously. This was in circumstances where his section 48 transfer had been cancelled, but not that he had improved; is that right?

A. No, that's right. In this case, my understanding is that the person had severe PTSD and that was the need for hospital treatment. It's actually illustrative of the fact that PTSD is not best managed in a detained or secure environment. People with PTSD should be managed, have to be managed, in a situation in which they're able to feel safe and secure and stable and to engage in treatment with somebody that they can build a trusting relationship with. So a secure hospital is not the ideal situation for somebody with that condition. Certainly an immigration detention is not. The ideal context is in the community, which eventually was

established in this case.
Q. To finish it off, he did eventually, on 3 April, some -- more than a month after he had been received into detention, have a rule 35(1) report completed on him by Dr Chaudhary, and he was, by the time of the rule 35 response from the Home Office, released.
A. Yes.
Q. So, eventually, the safeguard kicked in, but far too late, in your view?
A. Certainly far too late because harms that could have been foreseen on the second day of his detention, that he was somebody who had very high risk of deterioration in the detained environment because he was identified as having PTSD, was kept in detention so that his symptoms could be exacerbated, and suffering to the extent of causing a suicide attempt and so on, as you have explained.
Q. Rule 35(1) in particular, we have been talking about harm being caused in detention, but the rule actually only requires that it is likely to be harm -- likely to be caused, doesn't it?
A. Yes, that's exactly right. The fact that a rule 35(1) was done in this case when we know there are so few shows the type of extreme case that might trigger it in a GP, where a psychiatrist has recommended transfer to

hospital, but that really illustrates how people are left to deteriorate until such an intervention is required rather than flagged up, which doesn't fit with the idea of an Adults at Risk policy that should try to identify risk rather than actual harm, as in this case.
Q. It is required by the rule, isn't it?
A. Yes.
Q. As well. The rule isn't being applied in the way that it's supposed to be?
A. No, exactly, yes.
Q. Far too high a threshold, as Sandra Calver accepted, is being applied in relation to rule 35(1) reports, which perhaps is one of the reasons why we see so few of them?
A. Yes, exactly, because they are done when people have been allowed to deteriorate to such an extent instead of done to identify risk as per the policy.
Q. In terms of the reasons for the lack of rule 35(1) reports, part of the reason might be a lack of time and resources. Would you agree?
A. As I said, I just don't think that is an acceptable reason, because I don't think that's been flagged up as a reason. I think there's a failure to recognise the importance of the safeguards. There's a failure to recognise the risks people are facing in detention. And a failure to recognise the responsibilities of

the healthcare team and specifically of the GPs to implement these safeguards.
Q. That remains the case currently?
A. It does.
Q. As we know. Dr Oozeerally, in his live evidence on Friday, also placed reliance on the ability of the GPs and the mental health team to manage a detainee's health in detention as a reason not to do these reports. Do you have any comment upon that practice?
A. What we generally see is the GP's role is quite limited to prescribing medication or referring to the mental health team. The mental health team management is -- so there's mental health nurses in detention with access to psychiatrists, but their role is quite limited to assessment and some supportive interventions. They are not able to provide therapy, psychological therapy, in detention because, as I mentioned, in order to do that, you need the person to be in a safe environment in which they can engage with treatment, and this is really clearly explained in the Royal College of Psychiatrists' position statement, that the majority of mental disorders cannot be managed in detention, and that was a clear finding repeated in the Shaw Review in 2016, so known before the period of the inquiry. People couldn't get good care in detention for their mental health. So

the GP management is -- can't be seen as adequate. It is not equivalent to what would happen in the community.
Q. I'd like to move on to another case study, please, D1914. You look at this at paragraph 80(c) on page 30 of your statement. You comment that the rule 34 process didn't seem to have identified adequately his physical health issues. We know that he suffered from a serious heart condition and had a complex clinical history. He was taken to A&E by ambulance whilst he was at Brook House on multiple occasions after he complained of chest pains and palpitations and following a blood test result indicating a possible blood clot. Is that right?
A. Yes, that's all right.
Q. Does that sound to you as someone who has a stable cardiac condition?
A. No, well, I reviewed his detention centre medical records, and which included some letters from his cardiologist, and they show that he'd had a coronary artery bypass graft some time before he was detained and, although an interval had passed of some months, he was waiting for a further procedure, which was a catheter procedure, so an intervention through a blood vessel, to treat an abnormal heart rhythm. So when he said he was having palpitations, he had episodes of an abnormal heart rhythm for which he was awaiting

treatment. So we know he is a person with serious cardiac disease because he's required a coronary artery bypass graft and we know his condition has not been stabilised because he's waiting for a further procedure. All of that information was available in the medical records and it was known early on in his detention. So he could have been identified early on as somebody who had a cardiac condition which would have contraindicated specifically the use of restraint, which you might come to, and also meant he was unfit to fly.

Q. He didn't receive a rule 35(1) report until almost four months into his detention. In your view, should he have received one much earlier than that?

A. Yes. I think those medical vulnerabilities should have been flagged up very early on. He also had mental health issues and episodes of serious self-harm and suicide attempts in detention. So there were multiple indicators to flag up his risk in detention, which should have been done much earlier.

Q. Let's come to the use of force then. We know that D1914 was subject to a planned use of force in relation to an order to effect his removal to E wing on 27 May 2017 in advance of his charter flight. He had a serious heart condition, as we have just discussed, and he also, as you said, had a history of serious self-harm. He'd been

on three ACDTs.

Dr Oozeerally, as we heard on Friday, had written a letter to the Home Office that he was fit to fly and fit for detention. Was it appropriate, in your view, for GPs to be writing letters to the Home Office in such terms?

A. No, I think there's multiple issues with that. The GP's role in use of force is very strictly limited to a protective role. So they have no part in authorising or planning the use of force. It is not a therapeutic intervention. In this case, it was to remove him from the country. So it had nothing to do with his clinical care and, therefore, it has nothing to do with the doctors. Except that, in this context, they have a very specific safeguarding duty before, during and after a use of force, and so their role -- I don't think it's being too technical. Dr Oozeerally said the language amounted to the same thing, but, actually, the language is how we separate this role clearly in our documentation. So saying there's no medical contraindications is the limits of the doctor's involvement in a use of force.

Q. And it is very different from saying that he's happy for reasonable force to be used?

A. Absolutely, because that's an endorsement and that very

clearly steps beyond the boundaries that that doctor should have. This is clearly flagged up in guidance for doctors working in this area, so that the BMA report for doctors working in immigration detention explains about dual loyalties and how doctors can get drawn into custodial systems and, as GPs in that environment, they need to be constantly on their guard for that and really watch their language so that it's not, as in this case, used in another context to justify a use of force.

Q. Yes, as it clearly appears to have here. Dr Oozeerally also gave evidence that, in writing these letters in these sort of terms, he wouldn't always assess the patient in person in order to write such a letter. Was that appropriate, in your view?

A. Well, I think, in this case, there was enough information on the background information and the letters from the cardiologist to say that he was not fit to fly and to raise concerns about his restraint. But, clearly, for most people, they would need an assessment in person because it might not be that crystal clear, as I think it was in this case. There is also an issue about consent. So we are in a situation where a doctor is now going to share information with the detaining authority without having had a discussion with his patient about what's going to be shared and why and

whether or not there was consent for that information to be shared. Of course, that information, as he is the patient's GP in this situation, he needed to have the patient's consent to share that information.

Q. And he should have been raising both the physical condition and the self-harm as contraindications to the use of force prior to the planned use of force, in your view?

A. Yes, absolutely.

Q. And you remain of that view, even though Dr Oozeerally disagreed with you in his live evidence saying his condition was stable and neither of those things was a reason not to use force in this case?

A. I do remain of that view. I could see that Dr Oozeerally didn't have the medical records in front of him, but I have reviewed them before and since hearing that evidence, and I remain of that view, yes.

Q. You say also, in relation to D1914, at paragraph 145, that his case also appears to be an example of a misconception among staff that non-compliant behaviours are indicative of deliberate disobedience rather than a manifestation of underlying vulnerability, such as self-harm or mental ill-health or distress. Is that your view in relation to him?

A. Yes. So in relation to this person, I think there's

a very high risk that that is what was happening. There are snapshots, for example, in the nursing notes that this particular patient, D1914, was noted by the nurse to be very anxious, hyperventilating, tearful. We have seen, in the Panorama footage, unfortunately, evidence of very severe self-harm and suicide attempts, so a significant overdose, blood found in his room, very large cuts on his body. We have seen these manifestations of distress there and also in some snapshots in the medical entries. But the overall view is the treatment of him through custodial processes, through use of force, through ACDT. These are managing as behaviour. So they're management -- how you would manage if you didn't think somebody was unwell. There is no justification for managing somebody with mental health problems in a high degree of distress through these restrictive measures. So it is -- so recourse to them shows that the environment hasn't allowed this person to be treated as a vulnerable person, to be treated as a patient.

Q. Is that an attitude amongst the detention staff and the healthcare staff, including GPs?

A. Yes, I think there's a very high risk that those things go together, because if the GPs don't communicate those concerns and don't implement those safeguards, then they

are not feeding into an environment that would listen to people and treat them with compassion. They are instead participating in an environment that's hostile to those people.

Q. In relation to use of force in a different context, you comment about the issue of force being used in response to self-harm incidents. We have seen this in a number of cases -- D1527's is one, also D687, and one you discuss in your statement at paragraph 147(c), D812. In your experience, does it seem to have been a widespread practice to use force in response to incidents of self-harm?

A. Yes, absolutely. I would say there was very quick recourse to use of force rather than to a clinical intervention, and that's related to what I said to an environment that doesn't perceive these things as symptomatic of mental health issues, but reacts to them as challenging behaviours. So I think it's all connected. You mentioned D812, for example --

Q. 812.

A. -- who was subject to a planned use of force because of his risk of self-harm. So in that case, it's absolutely clear that the perceived indication for the use of force was a mental health issue, which was self-harm. And then, when he was found, unfortunately, it was with

a plastic bag over his head, so in the throes of a very serious suicide attempt. And still the use of force proceeded after that. So at a time when clearly what was needed was a compassionate mental health intervention.

Q. Yes, indeed, a shield was placed on his chest while he remained lying on the bed and he was then restrained prone on the ground, a dangerous position in itself?

A. Yes.

Q. His arms were restrained and his head was secured and he was escorted to E wing under restraint and in handcuffs. He dropped his weight to the ground several times, resulting in him being restrained again prone on the floor on at least one occasion. That does seem, as you say, to be a use of force as a tool to manage and respond to an acute episode of self-harm as opposed to merely to save life in the immediate moment. Would you agree?

A. Let me be clear. Force was rightly used to remove the plastic bag from his head. That was the extent of it. After that, he was no longer -- I don't think there is a suggestion he was posing risk to anybody else and after that had been done, he was no longer an immediate risk to himself. But, clearly, he'd just made a very serious suicide attempt. We can only assume that he

must have been distressed and frightened at that point when he was then subjected to the further use of force.

Q. And the role of healthcare staff present at that stage should have been to raise a concern about an ongoing use of force or a contraindication to do so; is that right?

A. Yes, absolutely. So the healthcare staff present should have said, "Stop", and tried to assess the situation, which means tried to assess his mental health and tried to engage him and to decide what was needed next. Now that the emergency had passed, they had time to do that.

Q. I think, lastly, then -- we have touched on the use of segregation in D1527's case, I just want to ask about D2951 and the use of segregation to actually provide clinical care. At paragraph 163, you say that there do seem to be instances of segregation being used in a direct attempt to provide clinical care and protection for highly vulnerable detainees, and D2951 is one of those. He suffered from significant mental health issues and was maintained on rule 40 segregation in early June 2017 whilst awaiting transfer to a psychiatric unit. So given he was awaiting transfer to a psychiatric unit, he clearly was significantly mentally unwell?

A. Yes.

Q. He appears to have been accommodated in a medical

single-occupancy cell in E wing subject to a three-man unlock. An IMB visitors report notes that E wing officers were concerned that leaving him locked in a room was detrimental. Would you also have been concerned?

A. Yes, absolutely. Leaving somebody alone in a room amounts to solitary confinement, and the impact of that on mental health is very clearly documented and known. So his mental health was at risk, not just through the prolonged increased isolation, but also due to the actual circumstances of being held in a single room.

Q. The Home Office continued to extend the authorisation for rule 40 at each review until his ongoing care was arranged, and during this period there were also concerns raised by the detention staff that leaving him in a locked room was detrimental to his mental state. He was eventually transferred to a mental health unit under section 48 on 15 June, but he appears to have come back to Brook House in early August 2017. The use of segregation in these type of circumstances, awaiting a transfer or awaiting treatment, psychiatric treatment, was an inappropriate use of segregation, in your view?

A. Absolutely. I think that's particularly concerning because now we are talking about the most unwell people that are actually assessed as in need of admission to

hospital.

Q. It is clearly not a substitute for mental health treatment?

A. Well, it's not a mental health treatment at all. It is actually -- it is worse than nothing, because it's actually something that would harm his mental health. So not only is it not therapeutic, but it is actually going to contribute to his deterioration.

Q. If someone is so unwell as to need to be segregated, does that suggest they shouldn't be in detention in the first place?

A. Yes, absolutely, because, as I have said, that is a harmful environment which is going to exacerbate their mental health condition.

Q. My last question before the break, I think, subject to any questions the chair has, is, I'd like to just ask for your view on any links between any of these failures we have just discussed in some considerable detail and the incidents we see of mistreatment captured on Panorama?

A. Thank you, yes. So I think it's impossible to really separate these issues. We are talking about failures of safeguards in rule 35(1), rule 35(2) and rule 35(3), rule 40, which means that vulnerable people are not picked up as vulnerable and they are kept in an

environment. So we are talking about a failure of safeguards to stop vulnerable people being in this environment. Then we are talking about an environment which has a known negative impact on mental health. So where behaviours like self-harm, like distress, like mental health problems are treated as challenging behaviour, so an inappropriate response, that leads to escalating mental health problems, increased risks of self-harm. It's a perfect storm, and, in that situation, we have people that are then unqualified to manage. Their only recourse is use of force, solitary confinement. They don't have the capacity to do a therapeutic intervention. So the possible responses are going to be inappropriate. I don't think it is possible to separate that from the abuses that we see.

MS SIMCOCK: Thank you. Chair, I don't have any further questions for this witness. Do you have any questions for her?

THE CHAIR: I don't. Thank you very much for your evidence, Dr Bingham. I know it is not necessarily an easy experience but it's been very important to hear from you.

A. Thank you.

MS SIMCOCK: Can I suggest quarter to?

A. Indeed, thank you.

(The witness withdrew)

(11.27 am)

(A short break)

(11.46 am)

MS SIMCOCK: Chair, the next witness is Theresa Schleicher.

MS THERESA VERONIKA PENNINGTON SCHLEICHER (affirmed)

MS SIMCOCK: Can you give your full name, please.

A. I have always worked as Theresa Schleicher. That's actually my maiden name. So my full name is Theresa Veronika Pennington Schleicher.

Q. Thank you. You are the casework manager at Medical Justice and have held that role since July 2009; is that right?

A. That's correct.

Q. What does that role entail?

A. I'm responsible for the individual casework we do. So I do some casework myself and I have three caseworkers working with me. We are the main point of contact for our clients who are detained. We then allocate clinicians who will carry out medico-legal assessments and we co-ordinate any follow-up work that we do for those clients. That might include advocating for them to receive appropriate healthcare, referring them, for instance, to legal representatives and making sure they receive care in the community when they are released.

I also feed into policy work that we do in the organisations. So I have regular meetings with our policy team and I have attended a lot of stakeholder meetings with the Home Office and other relevant bodies.

Q. What is the purpose of those stakeholder meetings?

A. With the Home Office, it is for us to give feedback on how Home Office policies are working on the ground, what we see in our work with detained people, and also the Home Office will often ask for our input in consultations on new policies that are being brought in.

Q. You say in your statement that your casework covers primarily three groups of people in detention: those who report torture, those who have a clinical problem and need an assessment of their treatment and support, and those who allege that they have been assaulted or subject to excessive force in detention or during an attempted removal; is that right?

A. That's right, and of course there is overlap between those three groups.

Q. How does Medical Justice receive referrals?

A. Just over half of referrals are self-referrals by detained people who ring up, and most of the time they have heard about us by word of mouth from other people in detention. And the rest comes from a mixture of sources. There are a lot of referrals from legal

representatives and then from visitors groups, from other NGOs who work within detention -- that could be Hibiscus or any of the other NGOs -- and sometimes from family or friends of detained people, from clinicians that work within the community or from a range of other social workers.

Q. What happens upon receipt of a referral? What's the process?

A. We take their initial details and then they get allocated to one of our caseworkers who will speak with them more, find out what the help is that they are looking for. We will ask them for all of the documents they have with them to have an understanding of what's happened on their case so far. We will request their healthcare records and then we have regular casework meetings, at the moment three times a week, where we discuss those cases and decide what we can do for those clients.

Q. Are you able to accept all referrals that come to you or is there a prioritisation?

A. Unfortunately not. So we accept about a third of the referrals that come to us. The rest we will try to signpost to other organisations where we can. But in terms of providing medical assessment and evidence for people in detention, of course we are the only

organisation to do that. So we prioritise on the basis of where we think our intervention is likely to make the biggest difference, and so, people who have survived torture, it is known that they are very likely to deteriorate in detention, so they are a priority. People who are very unwell, either mentally or physically, while in detention, again, they are a priority.

Q. You say at paragraph 19 of your statement that Medical Justice maintains a bespoke database. How many cases are on that database, roughly?

A. Oh, that's difficult to say. But we receive between 800 and 1,000 referrals a year and we have had the database since, I think, 2009, so they are all on there, a lot of cases. Obviously, for those who we take on, there's much more information on there because we will continue to update it while we work off the person. For those where we are not able to take on the case, there is only relatively brief details on there.

Q. What do you use the database for?

A. To record our ongoing casework. So any time we have contact with that person, we'll record that; any steps we plan to take, we will record; what they tell us about their health, we record; and we upload their documents, so their healthcare records and any immigration

documents we have.

Q. Does it perform a function in your policy work as well? Does it feed into that?

A. It does because it means we can then analyse themes that arise from the casework that we have done.

Q. You talk in your statement about the policy context providing a backdrop for your casework and that that's that vulnerable people, Adults at Risk, should only be detained in exceptional circumstances; is that right?

A. Exactly. I mean, that was accepted right from when the Detention Centre Rules first came in. It was made very clear that it was accepted that those who had survived torture or had mental health issues or other issues that made it very likely that they would deteriorate should not be put in detention because of that likelihood, so they should be screened out straight away either before entering detention or right after entering detention.

Q. As you say, it is because that cohort of people may be particularly vulnerable to suffering harm in detention?

A. Exactly.

Q. In your view, mere immigration factors such as entering the UK illegally, overstaying or refusing to leave voluntarily couldn't, or shouldn't, constitute exceptional circumstances; is that right?

A. Absolutely. And of course that was accepted by the

Home Office as well, until 2017 when the Adults at Risk policy came in.

Q. What, in your view, is the Adults at Risk framework and the safeguards under rules 34 and 35 designed to achieve?

A. So rule 35 and rule 34 have been there since 2001 and they were designed to identify vulnerable people at high risk of harm in detention, for them to be identified straight away on entering detention and to then be released. So that they wouldn't stay in detention and actually suffer harm. That process never really worked and there was then a number of findings of severely mentally ill people who suffered article 3 breaches while in detention. There were also a number of deaths that raised similar issues. Following that, Stephen Shaw was commissioned to review the process of detention for vulnerable people and the Adults at Risk policy obviously came out of that. Shaw identified that those safeguards weren't working effectively. He did say that the premise of having these groups of people that were identified who were at particular risk of harm was a good one and that that should be preserved and built on and he then suggested some additional safeguards. That's what we expected the adults at risk policy would do, but when it came out, actually it

didn't do that and we were really concerned that, instead, it looked like it was going to undermine the safeguards.

Q. In relation to defects in the rules 34 and 35 rules system for safeguarding vulnerable detainees, as you say, initially, at the outset of detention, but is there a role for those on an ongoing basis in detention?

A. Absolutely. I mean, I think it's really important that people are screened and identified before they even enter detention and that doesn't work, there is no proper process for that, and then those who are missed by that process to be identified as early as possible in detention. But, of course, some will be missed by that and so it's really important that there's ongoing monitoring, and that's why rule 35 is an ongoing duty to report people at risk of harm so they can then be routed out of detention as quickly as possible.

Q. What do you see as the main defects that remain in the system of rule 34 currently?

A. So rule 34. I think now most people, not all, but most people, who arrive in detention are seen by a GP within 24 hours, but that isn't an examination that can meet the purpose of rule 34. So it is not a targeted mental and physical examination designed at eliciting information about whether the person is at risk in

detention. It tends to be a really brief assessment to meet immediate health needs. For example, prescription of medication. So that doesn't identify people at risk of harm and, therefore, can't lead on to a rule 35 report. If people are identified at either the rule 34 stage or at the screening stage by a nurse, unfortunately that now doesn't trigger a rule 35 report immediately either. I think it used to more in about 2014. Those two rules seem to have become disconnected, and so, instead of a rule 35 report being done straight away, people are put on a rule 35 waiting list for a later appointment.

Q. We heard Dr Oozeerally talk about that on Friday. In your view, that's inappropriate and the rule 34 process should be leading to rule 35 reports immediately in appropriate cases?

A. Absolutely. The whole purpose of the two rules taken together is to identify people immediately and route them out of detention. So if, instead, a period is a -- a waiting period is allowed, that means people may deteriorate in the meantime.

Q. Do you have experience in relation to your casework of disclosures being made, for example, of being a victim of torture either to the nurse or to the GP that nevertheless didn't lead to a rule 35 assessment or

report at all?

A. Yes, absolutely. We have seen that frequently.

Q. In terms of the rule 34 assessment, or indeed rule 35 assessment, is there an appropriate focus by GPs on mental health and vulnerabilities in those assessments?

A. No. As far as we can see, mental health is often not properly assessed and not properly recorded.

Q. What's the consequence of that?

A. Often that's the key evidence that really needs to go to the Home Office and it means that that information isn't considered when detention is reviewed, and so, often, it means the person remains in detention when really they should not.

Q. Where rule 35 reports are being written, in your experience, are they of an adequate quality?

A. No. I think, often, important issues are left out that would have been really important to cover. For example, mental health symptoms. Sometimes comments are made that are really easily misinterpreted, like "no severe mental health issues" when there clearly are significant mental health issues, or recently we have seen the term "stable in detention" very frequently, which I think just means no issues so acute as to require hospitalisation. It doesn't mean no mental health issues that are likely to deteriorate. So that really

gives a wrong picture of what the situation is for the client.

Q. In those types of circumstances, would you be of the view that more rule 35(1) reports, for example, should be being written?

A. Absolutely. I mean, the absence of rule 35(1) and rule 35(2) reports is a failure that just means those safeguards are non-existent in practice.

Q. There really seems to be a focus primarily, if not exclusively, on rule 35(3); is that your experience?

A. Absolutely. But I think the purpose of rule 35(3) is being misunderstood, in that it often gets referred to as things like "allegation of torture application". And it is not an application by the person in detention, it is a duty on the doctor to report concerns. It is only because that isn't being done as it should that it then starts to be viewed as an application and detained people are having to go and ask for one or have their solicitors enquire about it.

Q. There seems to be an emphasis on a detainee seeking rule 35 reports rather than a view that there's an obligation on those on the other side of the equation to identify those people, make assessments and write -- and have GPs write reports. Is that right?

A. Exactly. Absolutely.

Q. And that's inappropriate?

A. That's completely inappropriate because a lot of people won't seek a report, they won't know about it. They might only find out about it once they have already been in detention for a period of time, at which point they may have suffered harm. It also leads to a perception sometimes, I think, that detained people are in some way demanding when they ask for a rule 35 report or that they can't wait and that's unreasonable. But of course, they shouldn't be in that position in the first place.

Q. Dr Oozeerally gave evidence about a misuse of the rule 35 system. Do you have any comment upon that evidence?

A. Yes, I thought that was quite shocking, really. There was some reference to rule 35 having been changed or expanded in some way, and of course that's not the case. Rule 35 has been the same since it was brought in, in, I think, 2000 or 2001, and has always been intended to pick up those, to identify those, who are at risk of deteriorating in detention. By reference to these protected groups who were set out in the previous policy as protected groups, that's now been converted into indicators. Because it's known that they would be particularly at risk and that's always included torture survivors. So those people seeking rule 35 reports or

groups arguing that they ought to have rule 35 reports because they fall within those groups is exactly what the purpose of rule 35 has always been intended to be. I don't see how that could be a misuse of it.

Q. If the system was operating as it was meant to under the rule, it is not, we know it is failing. But if it is operating as it was meant to, there would be no need to advocate for those people because they would already have been picked up; is that right?

A. Exactly. Exactly.

Q. You also speak in your statement about a concern that there's no oversight mechanism to monitor the operation of the rule 35 process; is that right?

A. That's right, yes. There are some limited statistics that are now being generated, but they are very much focused just on the numbers. There have been a few audit or dip sampling exercises that the Home Office has done. The first one was done after a lot of pressure from us and from other NGOs through the relevant stakeholder groups and the results of the sample were eventually lost.

The second one was published but it was completely focused on the procedural aspects of it, so that revealed that a certain number of reports were being done. Some there were long delays in the response times

and a significant number were completely lost and never responded to. Later, there were some dip sampling exercises that the Home Office did. What was never looked at was the content and why they weren't leading to release and what was happening to those people in whose cases it didn't lead to release, whether they were deteriorating, and that really is needed.

Q. So there's some limited audit of the numbers of rule 35 reports; is that right?

A. Yes, numbers of rule 35 reports broken down both by centre and by type, so (1), (2), (3), and then numbers of releases.

Q. But no further follow-up as to what happened in the cases that weren't released?

A. Exactly and also no analysis of the content of the reports. So, for instance, does it lead to detention being maintained if the doctor fails to comment on mental health? Those sorts of questions would be important to ask.

Q. So it is about the quality of the report?

A. The quality of the reports and the quality of the subsequent detention review.

Q. Have you raised those concerns with the Home Office?

A. Yes, we have raised them consistently. When I first started in 2009, I immediately started attending the DUG

and DUG medical subgroups, stakeholder groups -- that stands for "detention users group" -- and that was the main stakeholder group at the time for dealing with issues related to detention. That was attended by the Home Office, by Phil Schoenenberger and Simon Barrett, and then, later, that got subsumed into the NASF -- National Asylum Stakeholder Forum -- detention subgroup. Through these forums, and also in writing, we have, since 2009, raised these concerns repeatedly and have brought examples of how it fails, we have published several reports that touch on this and have brought this to the attention of the Home Office, but no effective action has been taken.

Q. What was their response?

A. When we bring examples, often we get told it is not possible to comment on things like that in such detail and that those are just individual cases and it wouldn't be appropriate to discuss them. When we bring general concerns, we are often told that these are too general and specific examples are required. At one point, there was an admission that there has been a disconnect between the doctor writing the report and the Home Office receiving them. But then no action was taken to address that disconnect. Forms were changed at one point and there was some consultation in relation to

that and we raised some concerns about the forms but they were effectively ignored.

Q. What were your concerns about the forms?

A. So in 2015, the form -- previously there was one form with tick boxes for rule 35(1), (2) or (3) and that was changed to three separate templates. We were worried there was a possibility that having these three forms may deter doctors from filling them in.

Q. Which seems to have been the case.

A. Which seems to have happened. We were also worried that the questions that were being asked may mislead the doctors into thinking the thresholds were higher than they actually were, which, again, is something that appears to have happened. I noticed that a couple of witnesses referred to the questions on the form indicating to them that there were certain steps they should take to monitor whether deterioration was occurring. And, of course, that goes entirely against the purpose of the rule, which is to identify people pre-emptively before harm occurs.

Q. Yes.

A. We also recommended -- we were -- we saw some of the training slides, not all of them. We were concerned about the content of that and we recommended audit and monitoring and that wasn't put in place.

Q. In relation to the definition of torture, we have heard that it changed. It was originally restricted to actions by estate agents and then it changed thereafter.

A. It was -- sorry. I don't mean to interrupt.

Q. Is there any concern about the current definition of torture in relation to rule 35?

A. So originally, the definition was wide. It wasn't restricted to estate actors. It was never specifically defined originally, but it was always understood by everyone to be very wide and that's because a wide range of people are vulnerable to suffering harm in detention. So who the perpetrator of torture was, for instance, clinically -- I'm not a clinician, but I understand from the clinical literature that that is not relevant to what harm it causes. So it was always very wide. Then in about 2012, there was a few Medical Justice clients challenged their detention in the courts. The case was later reported as EO. While that case was going on, the Home Office decided to limit the definition to UNCAT -- United Nations Convention Against Torture definition -- which is specific to torture that happens with -- either by estate actors or with the acquiescence of the state, and they used that to try to justify why, in some of the cases of those clients who brought those cases, why there hadn't been rule 35 reports. The

Home Office, at that point, argued that the definition had always been UNCAT but that was found not to be correct and, certainly, our experience was that was not correct. It was previously always wide. The judgment then said that, one, it had always been wider and, two, also there was no clinical basis for narrowing it, because the impact on people who weren't covered by UNCAT torture but were covered by a wider definition was the same, it was -- detention was likely to be very harmful to them.

After that judgment, the Home Office didn't implement that straight away so we had to send another letter threatening legal action until that was implemented. Despite this judgment having already found that there was no basis for narrowing the definition, the Home Office then sought to narrow it again with the Adults at Risk policy.

So I understand that witnesses have said that it was confusing, these changes. I think they probably were confusing and we were really concerned at the time that, one, they didn't reflect the clinical evidence and excluded people who were very vulnerable, but also that the narrower definition is confusing and difficult to apply. What happens with the acquiescence of the state -- it is a very complex question in lots of

cases and not one that GPs and detention centres are in a position to address correctly.

Q. You have also referred to the satisfactory management in detention threshold in relation to detainees who are unwell, a test that was effectively meant to be abolished following the recommendations made by the Shaw Review. Does there remain a concern about detainees who are unwell being managed in detention?

A. Absolutely. So this satisfactory management provision was exactly what led to those article 3 cases. Those were cases of mentally ill people who were allowed to deteriorate in detention because it was deemed that they could be satisfactorily managed. So that's the kind of level of harm that that caused. And in the aftermath of that, Shaw published his report and recommended a return to the category-based provision. Formally, the wording, "satisfactorily management" disappeared out of the policy. It doesn't appear in the Adults at Risk policy, but the way that that's constructed has essentially brought it in across the board. So level 3, which is what detainees have to get to, the evidence that they need to provide, to benefit from strong protection against detention, is to show that they would be -- that detention would be causing harm. And in practice, it seems to often be applied as it has already

caused harm or would be likely to cause harm within a very short period. So that's essentially the same provision now applied across all vulnerabilities, including torture survivors.

Q. So it is described differently, but, in your view, it is exactly the same test that's being applied?

A. Exactly, and it has been made integral to the way that the whole safeguard works.

Q. You heard the evidence of Dr Oozeerally and Dr Chaudhary, I believe, on Friday. They talked about the management of ill-health in Brook House and in particular that rule 35(1) reports were not being written if detainees could be managed in detention. Do you have any comment upon that practice that seems to be ongoing by them in Brook House?

A. Yes. I think that's -- that's exactly the practice that led to us seeing those breaches of article 3 and the terrible harm that was caused to those detainees. What I'm quite shocked about is that those doctors don't seem to appreciate that there is a lot of evidence that mental illness can't be effectively managed in detention. So there is not much that can then be done for those detained people who are deteriorating. At very best, what healthcare is able to do is accompany their deterioration.

Q. In 2019, the Home Office suggested widening the scope of who could make rule 35 reports. They suggested that it didn't need to only be a GP who could write a rule 35 report. What's your view about that suggestion?

A. I think it's really important that there is, overall, someone who is trained to be able to do this, who has the responsibility for it, so that other staff can report to that person. I don't see a problem in psychiatrists, for instance, being able to prepare rule 35 reports, but I think it is really important there is someone, like the GP, who is the prime responsible person for this, to make sure that it does actually happen. The other thing that was also proposed at the same time is not only that a wider range of professionals could complete the reports, but also rule 34 was being proposed to be downgraded to simply an appointment rather than specifically it being a mental and physical examination. When we queried this, we were told by the Home Office that, yes, of course there was going to be an examination, but we were really worried about this because, of course, at the moment, what we are seeing is that there isn't a proper examination taking place.

Q. Even though one is required under the rule?

A. Exactly. So we can only imagine what would happen if it

wasn't required.

Q. Otherwise, at least at that time, there were no other proposals for change to rule 35, despite Shaw's recommendation that there be a complete overhaul of that rule. What's your view about what should happen to rule 35 in the future?

A. It's never worked effectively. There have been lots of recommendations relating to it for a decade, and still no effective change appears to have been possible. I'm not sure that that is because rule 35 in itself, the way it is written, is deficient in some way. I think, in theory, rule 34 and rule 35 could play a really important role. I think there are lots of factors that feed into why it hasn't worked so far. Part of it, I think, is that it's never been properly prioritised. I think the culture of disbelief that exists both within the Home Office and within healthcare has fed into that. And I think there hasn't been the will within the Home Office to make proper changes to these safeguards. The only explanation we have been able to come up with for why that is is because the Home Office has just not been sufficiently interested in prioritising the welfare of vulnerable people in detention. The information has been on the table for a very long time, but I think instead removals and throughput through detention onto

the plane has been consistently prioritised.

Q. You've heard the way that Dr Oozeerally and Dr Chaudhary are applying rule 35 within Brook House, even currently.

A. Yes.

Q. Particularly that they are not conducting rule 35 -- not completing rule 35(2) reports and it seems, still, very few rule 35(1) reports. That's still clearly a concern?

A. Yes, that's still clearly a concern and that disables those safeguards, effectively. Because, of course, unless concerns are being reported to the Home Office, the Adults at Risk policy can't be applied. It is also an example of how lessons are not being learned. For example, rule 35(2) was a feature in several inquests that were reported but that information doesn't seem to be identified and fed back for those -- to those who work within the system.

Q. The concerns aren't just restricted, though, to the lack of rule 35(2) reports and rule 35(1) reports. The system, even under rule 35(3), doesn't appear to function adequately. What do you see as the main deficiencies in that part of the system currently?

A. On rule 35(3)?

Q. Yes.

A. So one aspect is what we have already touched on, the connection between rule 35(4) and rule 35(5) -- rule 35

that has disappeared. Then there is the issue that disclosures -- first, there is an issue with eliciting disclosure. So the expectation seems to be that a disclosure of torture would be made at the nurse screening, which can happen at any time during the day or night, in situations where the detained person is likely to be scared, bewildered, has just found themselves in a detention centre, so it is not a conducive environment for disclosures. If disclosure doesn't happen at that point, there is no follow-up that's sort of automatic. It's then relied on that the detained person will come forward themselves. If disclosure does happen, it may lead to a rule 35 appointment or it may not. If it does lead to an appointment, there is then a waiting time.

Later on, if the client comes forward and discloses torture, again, sometimes it leads to a rule 35 appointment, and sometimes it doesn't, and again there are waits. When the report is being done, a lot of clients report to us that it's -- they feel like they are rushed, they feel like the doctor doesn't believe them, isn't interested, sometimes clients report that they had the impression that the doctor thought that they were in some way wanting to use this for their immigration case and that there weren't clinical

concerns underlying it. Again, that's not conducive to trust and full disclosure.

When a report is then done, often the information is already known to healthcare. It is recorded in the healthcare records. It is often not reflected in the report. I think that appears in a couple of the case studies we have put together. Often clients will have presented repeatedly with significant symptoms to healthcare, those are recorded, but still the rule 35 report doesn't pick them up, doesn't analyse them in any way or link them to what the impact of detention might be. So if someone is starting to experience symptoms of PTSD, I'm not a clinician, but it doesn't seem to be a big jump to think that that's likely to deteriorate but that question doesn't seem to be asked. The question of the lurking impact of detention is often not addressed.

Q. So the quality of the reports remains a concern --

A. Remains a real concern --

Q. -- under rule 35(3)?

A. -- yes.

Q. Does that have a knock-on effect on the rates of release, in your view?

A. Absolutely. So the rates of release are low and have always been low.

Q. That's not a trend that's changing in any way?

A. It doesn't appear to. I mean, sometimes they have increased slightly only to dip again.

Q. Further Adults at Risk reform proposals were circulated, you say in your statement, by Ian Cheeseman in August 2020. Is that right?

A. That's correct, yes.

Q. Those did suggest a widening of reporting under rule 35 to the full range of vulnerabilities covered in the Adults at Risk policy. What's your view about that change proposed?

A. I think it is important that rule 35 is widened to the full range of indicators, but the problem with the proposal was that it didn't seem to want to focus on the indicators, but the idea was that, instead, it would focus purely on the impact of detention, and of course that's the bit that GPs are currently not adequately reporting. So we'd be really worried that it would instead entrench this sort of wait-and-see approach that we have seen.

Q. It was proposed that the evidence levels of (1), (2) and (3) under the Adults at Risk policy would be replaced by risk levels indicating low, medium and high risk of suffering harm in detention. What's your view about that?

A. I think that's really dangerous. I think the problem is that it's -- I mean, I'm not a clinician, but I understand from our volunteer clinicians and my colleagues that it's really difficult to predict who will suffer harm and in what timeframe. The best guide, I think, that clinicians have to make that decision is the groups that we know from research are particularly at harm -- at risk of harm. So survivors of torture, those with a pre-existing mental illness and so on.

So I think going further down the route of having very specific assessments of who is going to suffer what harm within what timeframe is not going to work because it is just not possible to make accurate assessments of that. Instead, what we think is necessary is to return to the original policy of having categories where it's known that they're at risk and then routing those people out of detention from the outset and not trying to see who is going to deteriorate how quickly, because then we get into the situation of -- I think Dr Hard may have suggested that it would be better to wait and observe and monitor and then document harm that's already occurred.

Q. It's certainly easier to do that.

A. I'm sure it's easier to do, but of course, then, preventible harm has occurred and we have talked a lot

about people deteriorating. I mean, I think it's helpful to remind ourselves what an awful distressing situation that is. Dr Bingham described what flashbacks are like. Some of the descriptions we have heard of what people have been like in detention, what they have felt, utterly, utterly terrifying and the harm often lasts long beyond detention. So if that can be prevented it certainly must.

Q. The further proposal in August 2020 was that the rule 35(1), (2) and (3) separate forms would be replaced again by a single form focused upon assessing the likelihood of the person being harmed in direction. You have talked about how really focusing on the likelihood of harm is not what, in your view, should happen. Would a single form though assist?

A. I think a single form may assist. Although rule 35 has never worked and there used to be a single form.

Q. So it wouldn't be --

A. So it is probably helpful to have great forms but I think tinkering with the mechanisms isn't going to solve the problem.

Q. In your view, the best proposal for change in relation to rule 35 would be to return to a category-based approach that covered all the relevant categories that are currently in the Adults at Risk policy, but that

that would then effectively automatically trigger rule 35 and release from detention thereafter unless there were the most exceptional circumstances?

A. Exactly. I think it would need to be combined with the most exceptional circumstances threshold for release. I think it would also need to be combined with effective pre-detention screening. I think there has been a lot of -- the doctors have given evidence that there is a lot of pressure on rule 35 in terms of time and, of course, part of the reason for that is that there are a lot of vulnerable people in detention.

Q. Yes. In relation to that screening prior to detention, in your view, the gatekeeper role used as a screening tool to assess vulnerability is a weak screening tool; is that right?

A. Yes, because there is no external input into it. It is purely internal. There is also no opportunity for the person who is about to be detained or their representatives to submit any information, so we have seen it to be quite ineffective.

Q. Is there a concern about how the balancing exercise of immigration factors against vulnerabilities is being conducted?

A. That as well, and that comes back to the problem that we have seen throughout this, which is that the Home Office

appears to, at every turn, prioritise removal over welfare. In one of the most -- more recent case studies that I appended to my statement is one of a man called HRB -- sorry, I need to deduce the initials from the name -- who was recognised as level 3 at the point he was detained. The gatekeeper authorised detention. It said reluctantly and only until scheduled removal, which was shortly after, and it was clear this man should have been released immediately when removal didn't take place. But when people enter detention, they get stuck in detention, and he remained in detention for a long period of time, deteriorated, as was expected, and that was completely foreseeable right from the beginning.

Q. There is a DSO04 from 2020 called "Mental vulnerability and detention". Does that DSO in any way address your concerns?

A. No.

Q. Why not?

A. So that DSO was proposed in the aftermath of the case of VC, which was the case of a severely mentally ill man at Brook House who was in segregation for long periods and suffered very distressing symptoms and didn't have capacity, and so he couldn't challenge his detention or the circumstances in which he was being held, force that was being used, him being in segregation. And so the

court identified that it was unlawful and discriminatory that there was no provision of independent advocacy to people in his situation. Nothing then happened until about 2019 when the first draft DSO was circulated for consultation, and, as often is the case, we were given a very short period of time to respond to it and some other relevant groups were not initially consulted, including the Royal College of Psychiatrists, and that draft DSO made no provision for that gap that had been specifically identified by the courts of the need for independent advocacy. We raised concerns about that and there was a bit of back and forth and another consultation a year later and, eventually, the DSO that he referred to was published and, again, that gap has not been filled and remains unchanged. So the DSO failed to address the main issue that was identified.

Q. So there remains, in your view, a gap in the safeguards in relation to those detainees who may lack the mental capacity to make decisions about their detention, their medical treatment in detention and other types of decisions?

A. Exactly. We continue to see people in detention, including at Brook House, including in the last few months, who lack capacity and who are not swiftly identified and assessed and who, even if they are

assessed, there is no provision for them.

Q. We heard from a witness from Freedom from Torture of quality standards in relation to medical reports provided to the Home Office on behalf of detainees and that those standards set too high a hurdle because they increased the standard of proof of professional medical evidence of vulnerability where that's from an independent person and not a practitioner working in an IRC. Is that your view also?

A. Absolutely. And I think those standards -- the introduction of those standards are a good example of the suspicion that existed in the Home Office of any safeguard that turns up a lot of people. This was looked at also by ICIBI who asked for the evidence. The Home Office said there was abuse of the safeguard that provides for MLRs -- medico-legal reports -- that apply the Istanbul Protocol being automatically level 3. And we haven't seen the evidence and neither has the ICIBI, even though they have asked for it, of that abuse.

What the Home Office has done to tackle this alleged abuse is to introduce these standards -- they are like a tick box. If a report doesn't meet all of the standards, then it is given less weight and often that means no weight in considering the detained person's detention.

Q. They are effectively disregarded if they don't meet every single tick box?

A. Exactly and some of the tick boxes don't have anything to do with the quality of the report. So, for example, one of them is that the same day the clinician, if they had concerns about the impact of detention, wrote a letter to the detention centre healthcare raising their concerns. A lot of the time, it is a good thing to send a letter straight away, but it doesn't have anything to do with the quality of the report. So we have, for example, come across a client, and he is also annexed as a case study, who was very unwell. He had severe PTSD and depression, he was deteriorating, he was suicidal. He was seen by an independent consultant psychiatrist arranged by his solicitor. This was a psychiatrist who didn't have experience of working within detention, so he was just unaware of the standards. He wrote a report, which was good, as you would expect from an experienced consultant psychiatrist, raising really serious concerns about the likelihood that this person was going to deteriorate even further in detention. But because he was unaware of the standards, he didn't meet them. So he didn't send that letter to healthcare the same day. Instead, he wrote his report really promptly and forwarded it to

the client's solicitor so that action could be taken promptly. But that wasn't enough and the report was disregarded. As a result, the client remained in detention for another month without this information being taken into account, until one of our doctors -- actually, Dr Bingham -- went in and saw him again and did a report in accordance with the standards. But that delay of that information being considered was completely unnecessary.

Q. You also comment in your statement that the standards entrench the practice of asking whether mental illness can be satisfactorily managed in detention. Is that right?

A. So the standards require the writer to consider whether the provision of healthcare on site makes any difference and require the writer to immediately communicate with healthcare so that healthcare can attempt to manage anything that has been found. That was one of the points that was criticised in that consultant psychiatrist's report that I have just referred to, that he didn't specifically refer to what treatment was available in the detention centre. What was quite clear from his report was that the client couldn't be managed in the detention centre. So the particular detail of what treatment and what staff were available didn't make

any difference. But, yes, the underlying assumption is that most things can be managed.

Q. That underlying assumption is wrong, in your view?

A. Exactly. And all the evidence, as Dr Bingham has explained, all the clinical evidence available shows that that assumption is wrong.

Q. You also comment in your statement at paragraphs 173 to 174 on the prevalence of use of force remaining a serious concern for the IMB 2020 report on Brook House. As far as you're concerned, is the use of force still a concern in Brook House?

A. Yes, absolutely. I think we see more of it when the detention centre fills up more and possibly a bit less of it when there are slightly lower numbers, but it continues to be a concern. I think it will always remain a concern, because, if you have high numbers of vulnerable people, who may present as distressed, who may self-harm, who may have disturbed behaviour, and you can't effectively manage their mental health, then you will get behaviours that, in the staff there -- the only response to that available to them are the use of force and moving to E wing or to segregation, and of course that's often accompanied by the use of force. So I think that's something that you -- that will always -- that's inherent in the way that this is set up.

Q. Yes, and use of force in relation to incidents of self-harm remains a concern?

A. Exactly, and the percentage of the use of force that was aimed at stopping self-harm was reported in the IMB report to have gone up. I think it was a third of incidents of the use of force that were for that purpose. But, of course, we know from the 2017 case studies and from more recent cases that when force is used to stop self-harm, it often doesn't stop at that.

Q. It was 37 per cent, in fact, so slightly more than a third --

A. So even more than that.

Q. -- but good memory. Dr Oozeerally in his evidence on Friday made a suggestion that Medical Justice is motivated by a political agenda, that immigration detention should be ended per se. Do you have any comment on that suggestion?

A. Yes, thank you for giving me the opportunity to respond to that. We do believe that detention -- immigration detention should be ended, but that is not a political view, that is based on our experience and that of our clinicians of working with people in detention and seeing the impact that detention has on their mental health. It is based on seeing how the safeguards have consistently failed and how the Home Office has been

either unwilling or unable to address that. So because of that, we see the only solution to deal with the harm that detention is causing on vulnerable people's health is to close them down. I don't think that's unreasonable. We are not the only organisation to propose that. The other main medical organisation who has considered this is the BMA and they have also recommended that immigration detention should be phased out. Other organisations have also thought that the safeguards aren't able to deal with the harm caused by detention adequately and that a time limit is needed. I think pretty much any body/organisation that has recently considered this issue has either recommended a fixed time limit or an end to immigration detention. I think even Dr Oozeerally himself recommended a limit of seven days.

Q. So your main proposals for change, your preference, would be to phase out the use of detention altogether, given the harm you have seen that it causes in vulnerable people?

A. (Witness nods).

Q. Or if not to phase it out completely, to limit the power to detain and in particular to put a time limit on detention?

A. (Witness nods).

Q. Assuming neither of those two things happens or is likely to happen in the immediate future, I think you make some recommendations or some suggestions for changes given immigration detention continuing, and some of them are set out in some detail in Emma Ginn's statement, who is the director of Medical Justice; is that right?

A. That's right, yes.

Q. I just want to ask you about some of them on her behalf. If you can't answer, please do just say.

A. Of course.

Q. They are contained in Ms Ginn's statement, which we will adduce in full. You say that detention -- or she says, I should say, detention should be a last resort and that all alternatives should be exhausted first, prior to detaining someone; is that right?

A. Absolutely. I think the only change -- reforms that have happened that have had a significant impact are those where there is both a time limit but also a process for considering the person's situation before they go into detention. So, for example, the family returns process requires a number of meetings before detention can be authorised and for information to be obtained from, for example, the person's GP or bodies that have provided therapy or social workers so that

there is information which can be considered, which, of course, the gatekeeper can't at the moment.

Q. Medical Justice makes some recommendations for reform of the Adults at Risk policy, and the recommendation or suggestion is that there is an urgent need to return to a category-based approach, as you have talked about somewhat in your evidence, to the identification of vulnerabilities, as indeed Mr Shaw recommended in his first report, where vulnerable people are treated as unsuitable, save in very exceptional circumstances. Is that right?

A. Absolutely, yes.

Q. Another suggestion is abolishing the requirement for specific evidence of risk of harm?

A. Yes. I think that goes with returning to a category-based approach.

Q. So the two go in tandem?

A. Absolutely.

Q. You say that there should be an effective screening of vulnerabilities, disabilities, trauma and mental health problems before the person is detained, and that, again, goes back to the gatekeeper role. In your view, should the gatekeeper -- the detention gatekeeper role be abolished?

A. The gatekeeper isn't independent in any way and doesn't

have any access to independent information, so that's why they're ineffective. I think a more independent setup would be more likely to be effective.

Q. A suggestion is made that that could be a detention review panel with a procedure for proactive enquiry, so that the panel is satisfied that there are no legal or practical barriers to removal and all relevant up-to-date evidence has been obtained and considered by the Home Office about the person's health and any other vulnerability?

A. Exactly. Quite often, when someone is in detention, a few months down the road it turns out that there was evidence that should have been available right from the beginning that they could not be removed anyway. For example, the -- for example, D1914. That information could have been made available right from the outset and he should never have been detained.

Q. You say a pre-detention screening must be coupled with an effective clinical screening process upon a person's detention. So where that process hasn't happened prior to detention and someone been screened out, there must be more than a tick-box exercise once they have been received into detention; is that right?

A. Exactly. So that's essentially rule 34 being properly implemented.

Q. So a proper mental and physical examination?

A. Exactly, focused and aimed at establishing some level of trust and eliciting disclosure of indicators that the person is at risk of harm.

Q. Medical Justice is of the view that rule 35 needs complete reform; is that right?

A. Absolutely.

Q. Part of that would be that rule 35 reports weren't routinely rejected and not leading to a release from detention; is that right?

A. Exactly.

Q. There is also an urgent need to address the disconnect between the rule 35 safeguard and the Adults at Risk policy and that's what the category-based approach would be designed to achieve, is it?

A. Yes, and also rule 35 would need to cover all the categories.

Q. Yes, which it doesn't at the moment?

A. Exactly.

Q. There are various suggestions about improving training and training has been a consistent theme.

Medical Justice would like to see better training for all healthcare staff in the delivery of trauma-informed clinical care and aimed at better identification of PTSD. You would agree with that?

A. I think that's really important. But I also think that training in itself is not going to solve that problem because training is going to struggle to get at that toxic culture that exists within detention and the culture of disbelief that's proven quite enduring.

Q. Further better training also on the Adults at Risk policy and rule 35, we heard consistent reports of a lack of, or a lack of adequate, training in those two areas that remain the case today; is that right?

A. Yes.

Q. There should be a focus on ongoing review under rule 35, shouldn't there, not just a one opportunity, either at the beginning of detention or when one rule 35 assessment is carried out. Dr Hard notes in his report there seems to be a complete absence of any follow-up to review the ongoing detention and its impact on someone; is that right?

A. Exactly. I think that's really important. But I think that review needs to be directed at identifying indicators that the person is at risk of deteriorating and not waiting for actual deterioration to occur.

Q. Yes, indeed. In Medical Justice's view, as both you and Dr Bingham have discussed, IRCs are not really a place to treat mental illness, are they?

A. (Witness nods).

Q. The suggestion is healthcare should have a responsibility to raise concerns about the suitability of the person for continued detention as soon as mental illness is identified; is that right?
A. Yes, exactly.
Q. There needs to be better training, as we have touched upon, in mental capacity as well?
A. Yes, absolutely.
Q. Part of the issues in relation to mental capacity you mentioned were the lack of a role for independent advocacy services. You would like to see the introduction of those in relation to the assessment of mental capacity?
A. Yes, and I think it is important that they would come in at quite a low level, so when there's suspicion of a lack of mental capacity or a concern about it.
Q. You would like to see the ACDT process linked with the Adults at Risk policy and rule 35, such that, as we have seen, does not currently happen and didn't happen in 2017. An ACDT would trigger the operation of rules 35(1) or rule 35(2) in the appropriate circumstance and reports made, or an alternative means for the Home Office reviewing detention?
A. Yes, exactly.
Q. In relation to use of force, the suggestion is that the

prison-based model of control and restraint is inappropriate for a detention centre. What would you like to see in its place?
A. A lot more focus on de-escalation and therapeutic interventions. I think, at the moment, measures that are likely to be perceived by the detainee as punitive are the first line of response to disturbed behaviour, which is often not identified as caused by mental illness, and so you get increasingly unwell detained people behaving in ways that are difficult to manage, and then you get more and more use of force, and of course, that's also distressing for everyone else there who witnesses it. It creates a sort of climate of fear and the situations in which the IMB, in 2020, said that the entire detained population was being subjected to inhumane treatment. And I think that's sort of inevitable when you get all these factors coming together in the way that Dr Bingham described as "a perfect storm". That's when the situation is utterly terrifying, probably for everyone involved. It fuels decentralisation, it fuels a normalisation of the use of force and of very distressed behaviour.
Q. And it exposes detainees to a risk of mistreatment?
A. Exactly. I guess the other thing that comes into it there is the racism that's been revealed both in

Panorama and in multiple other situations before, in dealing with Mubenga's case, who died while being forced onto a plane, in the undercover filming at Oakington and at Yarl's Wood and, as Stephen Shaw said after Oakington, being a detention custody officer is not a job just like any other. I think it does have an impact on people working in that environment to see the sort of disturbed behaviour, to see people routinely being subjected to the use of force, and of course detained people being people that their job is to manage out of the country, so the message is that they don't belong here. I think it is quite easy to slip into that these are people who don't have the same kind of worth. I'm not in any way an expert in organisational culture but I think it is unsurprising that this is an issue that has come up again and again.
Q. In relation to segregation, there are various proposals for change: that it shouldn't be used to manage or contain people who are suffering from serious mental illness or at risk of self-harming or suicide other than in the most exceptional circumstances where there is an immediate threat to that person's life; is that right?
A. Yes, absolutely.
Q. You would like to see any transfer to segregation for clinical reasons triggering a rule 35 report?

A. Yes.
Q. And indeed, thereafter release from detention unless someone's transferred to an inpatient psychiatric setting?
A. Yes.
Q. Because, of course, the importance isn't just the writing of the report but what happens with it?
A. Yes, exactly. The reports need to be properly effective. Even rule 35(1) reports don't always lead to release.
Q. Healthcare staff shouldn't be approving or authorising the use of segregation, in your view?
A. Absolutely.
Q. Their remit should be confined to raising contraindications or concerns and triggering a review of continued detention?
A. That's right.
Q. In your view, there should be a review of the use of E wing in Brook House as I think your view is that it is being used informally, so not under the safeguards of the rules -- rules 40 and 42, as segregation?
A. Exactly.
Q. And that can be very damaging to a detainee's, particularly mental, health?
A. Absolutely.

Q. In relation to monitoring and oversight, we have talked a little about gaps in oversight and monitoring by the Home Office. What would you like to see them do in order to strengthen their monitoring and oversight of the safeguards in relation to vulnerable detainees?
A. I think there needs to be proper monitoring and regular monitoring of not only the procedural aspects of it, but also the content and the effectiveness of it. But the other thing that needs to happen is that action actually needs to be taken. It was known that there was no rule 35(2) reports and very few rule 35(1) reports and somehow that doesn't seem to have rung alarm bells either within the centre or at the Home Office. So monitoring is really important, but it's not worth very much unless effective action is taken as a result.
Q. In your view, if these proposals for change were accepted and were actually to occur, is that likely, in your view, to lead to less risk of mistreatment of detained persons in detention?
A. I would hope so, but the reason I'm really cautious is because there have been so many recommendations and there are policies in place that on paper sound quite good if they were properly implemented: that's why we think, unless the power to detain is seriously curtailed, that it is inevitable that we see these sorts

of abuses.
MS SIMCOCK: Thank you. Chair, I have no further questions for this witness. Do you have any questions at all?
THE CHAIR: I don't. You have asked all of my questions that I had, Ms Simcock. Thank you very much.
MS SIMCOCK: So a slightly early lunch break. Should I suggest an hour, in any event, and we will come back at 1.45 pm?
THE CHAIR: 1.45 pm, thank you. Thank you for much for coming to give your evidence today. I know it is not an easy experience, but it has been very important to hear from you.
A. Thank you.
(The witness withdrew)
(12.45 pm)
(The short adjournment)
(1.45 pm)
MS SIMCOCK: The witness this afternoon is Joanne Buss. Thank you.
MS JOANNE MARIA BUSS (affirmed)
Examination by MS SIMCOCK
MS SIMCOCK: Can you give your full name, please?
A. Joanne Maria Buss.
Q. Ms Buss, you have made a statement to the inquiry which we find at <INN000025>. I am going to ask you about

some of the contents of that statement and I am going to show you some footage this afternoon and ask you some questions about it?
A. Okay.
Q. I may not ask you about every single line of that statement, because I am going to ask that the statement is adduced in full, which means it stands as your evidence to the inquiry. I'm just going to ask you some questions about your background as a nurse. You say in your statement, at paragraphs 1 and 2, that you have 38 years' experience as a general nurse; is that right?
A. Yes, that's right.
Q. Your experience of nursing in a custodial setting began when you worked for the Prison Service between 1994 and 1999; is that right?
A. Yes, that's right.
Q. And again for the Prison Service between 2001 and 2004; is that right?
A. Yes, that's right.
Q. You then worked at Tinsley House in 2004 and left in 2006 to work as an agency nurse, often working in local hospitals, and between 2008 and 2012, you also worked for the Police Service attending people in custody who required medical attention; is that right?
A. That's right.

Q. You say that, in 2010, you returned to Brook House and Tinsley House, initially working at Brook House, but soon after, in around 2010 or 2011, you moved to Tinsley House, where you remained as a senior nurse until 2017?
A. (Witness nods).
Q. Is all that right?
A. That's right, yes.
Q. In February or March 2017, you say you moved to Brook House, because we have heard that Tinsley House was undergoing refurbishment, so all the staff moved across; is that right?
A. Yes.
Q. You were promoted to the position of clinical lead for Tinsley House in May 2017, whilst still working at Brook House and, from April 2017, you say you didn't do much work with patients at Brook House because you were heavily involved in the preparations for the move back to Tinsley House?
A. Be from May.
Q. Thank you. You remained at Tinsley House until your suspension on 5 September 2017. You talk about your shifts at Brook House and you say you were there from 7.00 in the morning to 7.30 in the evening three days per week, and when you moved back to Tinsley House

in May 2017, your shifts became 8.00 o'clock in the morning until 4.40 five days a week; is that right?
A. 4.30.
Q. 4.30. I'm sorry, that's my mistake. I want to ask you something about the standards that apply to being a Registered Nurse. Nursing is a profession regulated by the Nursing & Midwifery Council; is that right?
A. That's right.
Q. Certain standards apply to being a nurse that you will obviously have been familiar with that apply irrespective of any additional rules that you were required to follow by your employer; is that right?
A. Yes, that's right.
Q. I just want to go through very briefly some of them and see if you agree. Those included putting the needs of your patients first and ensuring their rights were upheld, including challenging any discriminatory behaviour; would you agree?
A. Yes.
Q. Keeping accurate records and providing honest and accurate feedback to colleagues; would you agree with that?
A. Yes.
Q. In terms of the safety of patients, you were obliged to ensure you accurately assessed signs of worsening

physical and mental health in a person receiving care and to make timely referrals; would you agree with that?
A. Yes.
Q. You were required to act without delay if you believed there was a risk to a patient?
A. Yes.
Q. And to raise concerns immediately if you believed a person was vulnerable or at risk and needed extra support or protection; is that right?
A. Yes.
Q. Those applied just as much in detention as they would in any other setting?
A. Yes, that's right.
Q. Just dealing with what roles and responsibilities you had as a nurse in Brook House, you say that the team comprised qualified nurses and healthcare assistants, and there were mental health nurses as well as general nurses?
A. That's right.
Q. You would administer medication that had been provided by -- or prescribed by the GP; is that right?
A. (Witness nods).
Q. And you would triage patients who attended healthcare, making referrals to a doctor where necessary?
A. That's right.

Q. The mornings tended to be a walk-in clinic and the afternoons were when longer appointments took place?
A. Yes.
Q. In addition, a member of the healthcare team had to attend every incident, such as intoxication by drugs, use of force or acts of self-harm; is that right?
A. That's right.
Q. You decided, amongst yourselves, who would respond. A call would go out for healthcare to attend over the radio, and whoever was available --
A. Would go.
Q. -- one or two members of the team would go?
A. Mmm.
Q. There was also a role in screening new arrivals into Brook House in terms of reception screening; is that right?
A. That's right.
Q. Did you ever undertake that role?
A. We all did, yeah.
Q. And that often led to the identification of vulnerabilities, such as mental health issues or risk of self-harm requiring an ACDT; is that right?
A. That's right.
Q. You would have been familiar with the system under the ACDT to manage self-harm and risk of suicide?

A. Yes.
Q. You say the tasks -- these tasks were time consuming and there was an unrealistic expectation of what the team could deliver. Are you talking there about understaffing?
A. Understaffing, the volume of people that could come in on any one day, the length of the assessment and, if you had to do referrals, you all had to make doctors appointments for the next day. Yeah, it was just not -- not easy.
Q. That's specifically in relation to reception screening?
A. That's reception screening.
Q. I want to deal then with the NMC proceedings that were taken against you as a result of the incident that was shown in Panorama. I just want to look at the result of those hearings. So there was a hearing -- following a hearing on 23 February 2021, so quite recently.
A. Okay.
Q. The NMC struck you off the nursing register as a result of your actions on 25 April 2017, and what they referred to as your failures to safeguard D1527; is that right?
A. I was struck off, yes.
Q. The charges against you were that you, as a Registered Nurse, on 25 April 2017 at Brook House Immigration Removal Centre, one:

"Failed to take steps to safeguard person A [who we know is D1527; that was how the Nursing & Midwifery Council referred to him] in that you did not intervene when person A was inappropriately restrained by detention officers."

That was the first charge. The second was:

"Made an inappropriate comment in relation to person A, referring to him as 'an arse'."

The third:

"Failed to undertake and record observations on person A following the use of force and restraint on person A by detention officers."

Fourth:

"Made an inaccurate entry on person A's medical records omitting the use of force and restraint by detention centres on person A."

Fifthly:

"Your actions in relation to 4 above [that's the entry in the notes] were dishonest in that you deliberately sought to conceal that force and restraint had been used by detention officers against person A."

In conclusion, they said, in light of the above, your fitness to practise was impaired by reason of your misconduct. Are those familiar to you as the charges against you by the NMC?

A. Yes.

Q. On 16 February 2021, you emailed the NMC and made a full admission on all charges, and we find that at <INN000026>, which is the exhibit to your witness statement to the inquiry. Do you remember that?

A. That email?

Q. Yes.

A. Yes.

Q. In your witness statement to the inquiry, you now confirm that your position has changed, and you effectively deny all of those charges, except for the one at charge 2.

A. I do.

Q. Which is the comment.

A. Yes.

Q. Can I just summarise, then, what your position is now, in relation to those charges. In summary, what you say is, you now have no memory of the incident, but, based upon your review of the video footage, you believe you've been treated unfairly by G4S and the NMC. You accept and apologise for calling D1527 an "arse", but say that the door to his room was shut and there was no possibility that he could have heard the comment; is that right?

A. That's right.

Q. Thirdly, you did not see DCO Paschali's hands around D1527's neck and, had you done so, you would have definitely stopped to intervene; is that right?

A. Of course I would.

Q. Your handwritten notes were brief because you were suffering pain in your hand, not because you were trying to cover up the facts; is that right?

A. That's right.

Q. You recorded the use of force incident by DCO Paschali, DCO Tulley and others in your medical records, as you were required to do, and that you recorded the events and D1527's injuries appropriately, being to update the ACDT record, update the SystmOne record -- that's the medical notes -- and to complete a form F213; is that right?

A. That's right. I asked somebody else to complete the 213 for me.

Q. Absolutely. We will come to the detail of that in a moment. But your position is essentially that you completed the required records?

A. I did.

Q. The level of detail recorded in your notes was not unusually brief and should not be seen as evidence of collusion or a coverup. Essentially, you say the records you made were adequate; is that right?

A. Yes.

Q. You say the records were correct and appropriate, having regard to the circumstances you witnessed?

A. Yes.

Q. So that accurately summarises what your present position is; is that right?

A. That does.

Q. Before we come, then, to the specifics of the incident on 25 April 2017, I just want to ask you a few questions about your memory of events. In your statement at paragraph 8, you refer to a distressing incident you witnessed in the Prison Service in 2001. I'm not going to ask you about that in any detail. But you say that it changed the way you approached work generally. At paragraph 10, you say that you found the only way to cope with working at Tinsley House and Brook House was to completely leave the events of the working day behind you when you left work for the day; is that right?

A. That's right.

Q. Do you think that made you somewhat detached from your work at the time?

A. Not when I was working, no, but when I left work, everything stayed at work. It didn't come home with me.

Q. I see. Do you think that you became at all desensitised to the things that you saw at Brook House, such as

incidents of self-harm?
A. No. No.
Q. Do you think that your approach to work in that way compromised your ability to do your job?
A. No.
Q. Do you think that you recognised and responded appropriately, then, to vulnerable detainees experiencing mental ill-health?
A. As far as I'm aware, yes.
Q. You say, when you were interviewed in September 2017 by G4S -- it's been suggested that you were deliberately vague, and that's not the case. You simply genuinely couldn't remember very much about the events of that day?
A. That's right.
Q. In relation to -- can we have it up on screen, <TRN0000100> at page 8, please. Ms Buss, this is, as that first page said, a transcript of a conversation that you had with DCO Callum Tulley on 3 May 2017, so some days after the incident on 25 April. Here you discuss D1527 and the events on 25 April with Callum Tulley and another officer in the staff room. If we look at line 210, the line numbers are on the left-hand side, you say:
"Never seen anything like it. You know the

observation door on E wing? His feet were going up -- up the door, fucks sake."
Callum replies, and you continue, and you say:
"Strangling, yeah, but a phone battery at the -- those flat -- a Nokia battery that he wanted to swallow. But he self-strangulated, then he went up the door, then he had a massive hissy fit on the floor. And apparently, a couple of hours later, he was as right as rain."
Would you agree that at least on 3 May you remembered this incident because you were talking about it then?
A. I would have remembered some of it because it was quite fresh.
Q. Yes.
A. But it wouldn't have stayed in my memory.
Q. You describe that you had never seen anything like it. That suggests, doesn't it, that the event was very memorable to you?
A. I don't know. I wouldn't know.
Q. But your position today -- we are obviously some five years on, almost -- speaking now, is that you didn't remember very much about the events on 25 April at all, and you are essentially going on your viewing of the footage; is that right?

A. Exactly, yes.
Q. Just while we are on this transcript, given we have got it, was "a massive hissy hit on the floor" an appropriate way to describe D1527's condition and presentation on 25 April?
A. No, probably not.
Q. He was in an acute mental health crisis, wasn't he?
A. He was upset.
Q. Does "upset" accurately describe how he presented on that day?
A. He was under the care of the mental health nurses, who kept him under their care. I had no knowledge of this man at all.
Q. But he was more than upset, wasn't he?
A. He was angry.
Q. He was angry and upset?
A. From what I can recall.
Q. Wasn't he very unwell?
A. I don't know. He was under the care of the mental health nurses, the mental health team, and there was an RMN with him.
Q. He had attempted suicide?
A. He'd attempted to self-strangulate, I believe.
Q. And he'd attempted to self-harm prior to his move to E wing. He was very distressed, wasn't he?

A. He was distressed.
Q. Were you attempting there to suggest that his actions were a deliberate manipulation rather than due to mental ill-health?
A. Not at all.
Q. That he was attention seeking?
A. Not at all.
Q. Having a tantrum like a child?
A. Not at all.
Q. "Hissy fit on floor"?
A. Not at all.
Q. Was the comment about him being right as rain in a couple of hours meant to convey that it had been attention-seeking behaviour deliberately and not as a result of underlying mental ill-health?
A. No, I suspect from -- just thinking about it, is that he was okay afterwards.
Q. Thank you. That can be taken down. If we look, then, at the background to the incident on 25 April, D1527 had been removed to E wing due to his self-harming behaviour, hadn't he? Do you remember that?
A. Yes, he's been moved.
Q. Was that not just with D1527, but was that a common occurrence, that detainees who self-harmed were often moved to E wing to be observed?

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

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

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

force?
A. For a planned use of force, yes.
Q. Would it involve an assessment of the detainee in person?
A. Not necessarily.
Q. Would it involve carrying out a risk assessment in relation to the use of force on them?
A. I don't know.
Q. Did you ever carry out this role of attending a briefing and then, subsequently, in the actual planned use of force itself in 2017? Was it something you did?
A. Maybe before/up to 2017.
Q. Did you ever advise that force should not be used on a detainee due to their mental ill-health or vulnerabilities?
A. Several times.
Q. What happened in those times? Was there still a use of force carried out or not?
A. I don't know. But there have been times when use of force has not been carried out.
Q. Did you ever advise that force should not be used on a detainee who had self-harmed?
A. I would think so.
Q. But you don't know?
A. You're asking me five, six years, seven years ago,

I don't know.
Q. You can't remember?
A. No.
Q. I'm sorry, I have just been told that people on the live feed are struggling to hear you. Would you mind just ever so slightly keeping your voice slightly louder?
A. Okay.
Q. You say in your witness statement, at paragraph 47, that use of force to prevent self-harm is not uncommon. Were those mainly unplanned uses of force in direct response to an incident?
A. I would think so.
Q. Let's come then to the incident on 25 April. At paragraph 19 of your statement, you have essentially summarised the key footage and your observations on it. I just now want to play some of it -- not all of it, but some of the footage -- in relation to the incident. If we could start, please, with KENCOV1007 V2017042500020. If we can start at the counter time of 06:56, please, and play until 07:09, if that's possible, or thereabouts.
(Video played)
MS SIMCOCK: Pause there.
You deal with this time in your witness statement where Steve Loughton says "The use of force, flipping

paperwork", and saying -- he makes a reference to the use of force paperwork, but we can hear on the footage that he also refers to D1527 as a "cock" too, can't we?
A. Yes.
Q. That's clear from the footage. Why is that not included in your witness statement?
A. I don't know.
Q. It's picked up by DCO Tulley's undercover camera whilst he's sitting directly opposite D1527, so it was within his earshot, wasn't it, that comment?
A. Yes.
Q. You were in the cell. Do you remember hearing that?
A. No.
Q. Do you accept you would have done, in the circumstances?
A. If I'd have heard it, I'd have questioned it.
Q. Well, do you accept that, given it's picked up by DCO Tulley's camera on this footage, and that you were in the cell as well, that you would have heard it, in the circumstances?
A. Possibly.
Q. You didn't challenge DCM Loughton. You should have done, shouldn't you?
A. If I'd heard it, I would have done, but I can't convinced -- I'm not convinced I heard it.
Q. It was a completely inappropriate comment by him, wasn't

it?
A. It was inappropriate.
Q. Within earshot of D1527?
A. Yes.
Q. We will come to it in a moment, but we know you accept that you later referred to D1527 as an "arse". Did DCM Loughton's view that he was a "cock" also represent your view?
A. Maybe. I can't remember. I wouldn't know.
Q. It's similar language, isn't it?
A. It is similar.
Q. If we can carry on playing, then, please, from where we are to 07:29.
(Video played)
MS SIMCOCK: So this is a conversation in the presence of D1527 between Nathan Ring -- in your presence, which you respond to, where Nathan Ring says:
"Going all night, isn't he?"
You reply, "Yeah". Nathan Ring says:
"Going all night. Duracell bunny, isn't he? Swallowing batteries."
And then "You're full of it" and then "Burn his tongue". In your witness statement, you said that the "Yeah" we hear on the footage doesn't mean that you agreed with the joke that Mr Ring was making and that

you had not appreciated that he was even making a joke and that your response "yeah" was because you had thought that you might be required to remain with D1527 for some time and that it was clear you hadn't appreciated the nature of the comment by DCM Ring by the fact that he goes on to explain his comment after he makes it. Is that right? You didn't understand that he was making a joke at D1527's expense?
A. No, I wouldn't have cottoned on to that at all.
Q. If that's right and you didn't understand it initially, which caused him to explain it, you certainly knew by the time he'd explained it, didn't you?
A. By the time he'd explained it.
Q. Because, as you said, that's what you say in your witness statement, he explained it?
A. Yes.
Q. You didn't challenge him on that comment, did you?
A. No.
Q. Despite the fact it was said in front of D1527. Why not?
A. I don't know.
Q. Did you think it was appropriate for him to be making a joke about D1527, who had attempted to self-harm by swallowing a phone battery?
A. No.

Q. If we can play, please, from 07:50 to 08:15, thank you.
(Video played)
MS SIMCOCK: I'm told there is still an issue with us hearing through the mics. If you could just try. I know it is difficult. If you could just try to keep your voice up, we'd be very grateful.
What we just heard played on the footage was Nathan Ring referring to D1527 as a child. He says:
"A child, you know [something inaudible] which isn't going to happen."
You reply "No" and Nathan Ring says:
"They just sit and sulk."
In your witness statement, at page 8, you say you're not sure what you meant by "no", whether you were simply acknowledging that DCM Ring was speaking to you, or agreeing that the behaviour of D1527 would not result in his return to normal association, or the behaviour of D1527 would be more likely to result in a longer stay in E wing because it would not be considered safe for him to be on normal association. Weren't you there agreeing that D1527 was acting like a child?
A. I don't see how.
Q. Nathan Ring and Charlie Francis have both given evidence live to the inquiry that they thought he was behaving like a child and being manipulative. Was that your view

of how he was behaving at the time?
A. I don't know. I can't remember that in detail.
Q. In your witness statement, you refer to D1527 staying on E wing due to his behaviour. Does that indicate a view that D1527 was deliberately acting inappropriately, as opposed to being in an acute mental crisis?
A. No.
Q. Did you think that D1527 was being treated appropriately by staff here?
A. This was the first time I'd had any contact with D1527.
Q. Is it appropriate to make these kind of comments about anyone who is suffering from mental illness and self-harming?
A. No.
Q. Can we play, please, from 14:07 to around about 14:18.
(Video played)
MS SIMCOCK: We see you there leaving the cell with Nathan Ring, don't we?
A. Yes.
Q. He, on leaving the cell, says, "Like a Duracell bunny, fully charged", and then he jumps up and down. Did you see that?
A. Yes.
Q. That's you in front of him when he makes that comment, and we can see that you see him jump up and down, can't

we, from the footage?
A. Yes.
Q. In your witness statement, you say, 22:58, which is the timing on not the counter, but the timing on the clip:
"I can be seen leaving D1527's room but remain just outside the door."
You don't mention in your witness statement anything about Nathan Ring's comment, do you?
A. No, it probably would have gone straight over my head.
Q. Nor the action he does, jumping up and down, presumably his impression of a Duracell bunny?
A. It would have gone over my head. I probably wouldn't have noticed it.
Q. But you clearly heard and saw it, as we can see from the footage?
A. I will have heard and saw it and probably just passed it over, just let it go over my head.
Q. It is clear he is making a joke at D1527's expense, isn't he? There is no question about that?
A. Appears to be, yes.
Q. Would you accept that that's inappropriate?
A. Yes.
Q. You didn't challenge him, we see from the footage. Why not?
A. Because I suspect it's probably gone straight over my

head as just part of day-to-day life in Brook House.
Q. Acceptable?
A. No. But normal.
Q. Normal. Were you trying in your witness statement, by not mentioning your involvement in this inappropriate behaviour of staff towards him, to minimise that -- to distance yourself from that behaviour?
A. No. I've got no reason to.
Q. Can we look, please, at KENCOV1007, and it is the V number that ends in 21. This is the build-up to the incident in the cell with Yan Paschali. If we can play from around 01:26 to about 02:05.
(Video played)
MS SIMCOCK: I think with this one the two times are the same, so the clip time and the counter time are the same. Thank you.
(Video played)
MS SIMCOCK: So we see here that you're, again, outside D1527's cell, and you talk about doing the earlier form and visual obs, and you say in your statement that's a reference to the D213 form or the use of force form from the first incident that DCM Loughton attended the previous day. Do you think that's right?
A. I wouldn't have completed a use of force form.
Q. But do you think that reference is to the earlier

incident?
A. I don't know. I don't think so. Maybe. I don't know.
Q. Callum Tulley says:
"Do you know what, actually, his problem is?"
This is when you respond with the comment "He's an arse, basically", and you say, "He can't get what he wants. He can't get what he wants and I can't get what he wants."
What you say about this in your statement, at page 11, is:
"I regret referring to D1527 in this way and I apologise to him for doing so. However, the door to D1527's room was shut and there is no possibility he could have heard the comment."
You accept it is still an inappropriate comment to make, even though he couldn't hear you?
A. Yes, I do, and I have apologised for that.
Q. "He can't get what he wants and I can't get what he wants", suggests his behaviour was deliberate, doesn't it, rather than as a result of mental ill-health?
A. Maybe.
Q. The comment was derogatory. Was this your genuinely-held view of him at the time?
A. Probably not, no.
Q. That he was being, effectively, deliberately annoying,

causing you trouble, attention seeking?
A. No.
Q. Did you consider that he was in the middle of an acute mental health crisis at this stage?
A. I considered he was probably unwell, yes.
Q. Did you have in mind that he'd attempted suicide on three occasions in 24 hours and had refused food for six days before this?
A. No, I didn't know anything about that.
Q. If we could play, then, please, from 02:05 to 04:00, please.
(Video played)
MS SIMCOCK: In fact, we can pause there, thank you. This shows you and a number of different officers, DCOs Tulley and Fraser and DCMs Ring and Yates all observing D1527 from outside the cell and chatting to each other. Do you agree?
A. Yes.
Q. What was the purpose of you all being outside his cell at this point?
A. I don't know.
Q. Did you consider at the time the effect that that many people outside talking about him and observing him, the effect that it would have upon him?
A. No, I'm just there for a medical perspective, not to --

just to make sure he doesn't hurt himself.
Q. If we could go forward then, please, to 06:14 and then play until 06:30.
(Video played)
MS SIMCOCK: In your witness statement at page 12, you note some of the comments by DCM Ring here, but not all of them, and you simply state:
"Throughout these comments, I can be seen looking at the floor."
Was there a reason you left out the comment about the battery being a dummy from your witness statement?
A. Probably went over my head again. If you work in that environment, you kind of ignore a lot of the banter that goes on.
Q. Yes.
A. You can't take -- you can't take it on board. You just do what you're there to do.
Q. Were you, in your witness statement to this inquiry, trying to minimise your complicity in inappropriate behaviour?
A. Not at all.
Q. You're inside the cell at this point, and clearly within earshot of D1527, aren't you?
A. I should think so, yes.
Q. Those are inappropriate comments by DCM Ring. Would you

agree?
A. Yes, I would agree.
Q. You didn't challenge them at the time, and you didn't report them. Why was that?
A. Probably because they went over my head as banter.
Q. Let's look, then, please, at 07:05 to 08:25, please, and this is the incident with Yan Paschali.
(Video played)
MS SIMCOCK: So Callum Tulley is left alone to observe D1527 in his cell, and from about 07:08, he starts to self-strangulate, leading to the restraint in which Yan Paschali uses his hands on his neck, which has been referred to as "the choke hold incident". About this, you state the following in your statement at page 13, about the choke hold incident itself. You say:
"[At] 00:08:23 -- the noises made by D1527 become louder and DCO Paschali is shown taking hold of D1527 with his thumbs around D1527's neck/throat. DCO Paschali instructs D1527 to 'relax'. I did not see DCO Paschali's hands around D1527's neck or throat and had I seen this I would definitely have intervened to stop it. The same applies to the earlier occasion between 00:08:00 and 00:08:08, although it is not clear from the video whether DCO Paschali has his thumbs around D1527's throat during this period. I am certain

that I was not in a position to see the hold on D1527's neck because I know that I would have intervened otherwise."

So your position now is that you couldn't see DCO Paschali choking D1527 because you would have intervened, had you seen it; is that right?

A. Absolutely.

Q. But you would have heard the choking sounds he is making, wouldn't you?

A. I would have heard the noise, but also I would have also expected other officers there that had concerns to help me with my -- being able to see to say something.

Q. Did the noise he was making not concern you, as the healthcare person there?

A. Not at that moment.

Q. Was that the usual sort of noise that a detainee would make during a restraint?

A. People do grunt and make noises.

Q. But that's more than that, isn't it? It was a choking noise?

A. I can't recall that, and I'm not going to comment on that.

Q. Well, you have heard it on the footage --

A. I'm not going to comment that it is a choking noise or not.

Q. You don't want to?

A. No, I'm not going to because I didn't see the restraint, I didn't see -- if I had have done, I'd have stopped it.

Q. However we describe it, whatever particular word we use, we have just all heard it. That should have prompted you to raise a concern, shouldn't it, in your safeguarding role as the healthcare person there?

A. If I'd heard it clearly or I'd had concerns that he was being injured, yes, I would have done --

Q. It was your --

A. -- but I didn't, so ...

Q. It was your responsibility to safeguard his welfare, wasn't it?

A. If I'd seen it, I would have stopped it, and if I'd heard it, I would have stopped it.

Q. Dealing with what you could see, at paragraph 42, you say that there was a restraint involving four DCOs and a detained person, all physically struggling in a confined space. So you could see that?

A. I could see the bodies, yes.

Q. We know from the video footage, although you could see that, you say nothing during the physical struggle, do you? You don't raise any concerns throughout the entirety of this incident, do you?

A. No, not at that point.

Q. Did you not consider at the time that this struggle, as you call it, might cause him harm, given his vulnerability?

A. I couldn't actually see what they were doing.

Q. We will come to that in a moment. But you could see that there was a struggle with four DCOs, as you have described it. Didn't that concern you at the time?

A. When it's that chaotic in that small a space and I haven't got vision, I can't see. If I'd seen, I would have stopped it. I'm not frightened to stop a C&R.

Q. Why were you not advising this level of restraint to end at this time?

A. Because I couldn't actually see what was happening.

Q. Did you make any efforts to try to reduce the risk of harm to D1527, given what you could see?

A. What do you mean?

Q. Well, did you make any efforts at all to do anything to reduce his risk of harm, given what you could see?

A. I couldn't see hardly anything, so I can't comment. But I can also say that officers -- there were three officers there. One of them could have said, if they'd had concerns, they could have raised concerns. Callum Tulley could have raised concerns. He didn't.

Q. We will come --

A. And the other officers didn't.

Q. We will come to what Callum Tulley does in a moment. But you are the healthcare person present, aren't you? Your role, your safeguarding role, was to monitor his welfare from a clinical perspective and to safeguard his welfare by raising concerns. You didn't do anything in that regard, did you?

A. I can't raise a concern for what I don't see.

Q. If we could play, please, from 08:25 to 08:42.

(Video played)

MS SIMCOCK: The Yan Paschali comment, "I'm going to put you to fucking sleep", you say you didn't hear that.

A. No, I didn't.

Q. It is completely inappropriate, isn't it?

A. It is an inappropriate comment, yes.

Q. It is a direct threat. Do you agree?

A. Yes.

Q. You say, if you'd heard that, you would have intervened; is that right?

A. Absolutely, yes.

Q. Even though you didn't intervene when other inappropriate comments were made in your presence?

A. Those I've described to you as -- just washed over like banter. But that was inappropriate. But I would have expected somebody else to have mentioned that that had been heard, just to make me aware of it.

Q. In relation to DCO Tulley, you have said he didn't intervene. He clearly instructs DCO Paschali, "Easy, easy", doesn't he?
A. He does, but could he have not --
Q. Did that not concern you?
A. Because I wouldn't have heard that. Could he not have turned to me and said, "Jo, I think something is happening here. Can you have a look".
Q. We heard it on the footage. It is quite a loud command, "Yan, easy, easy". You still say you didn't hear that?
A. I don't think it was very loud.
Q. If we, please, just go back a few seconds. If you could keep your eyes, please, on the right-hand side of the picture, and if we just play it again through to 08:43.
(Video played)
MS SIMCOCK: Did you see there that to the right of Yan Paschali kneeling there was an individual in the picture standing, with their feet and legs visible?
A. Yes.
Q. As we play the footage, you can see that the individual walks around from behind Yan Paschali to his left, and by the time they're past him, they would have had a view of where his hands were on D1527's neck. Do you agree with that?

A. Yes.
Q. That's you, isn't it?
A. That is me.
Q. So you would have had a view of Yan Paschali's hands on D1527's neck, wouldn't you?
A. No, not necessarily. I say --
Q. Why not?
A. As I say to you, if I'd seen it, I would have stopped it.
Q. What you can see is him being pinned on the floor by the officers present. You still didn't raise any concerns at this point. Why not?
A. I obviously wasn't aware of it. I'd have stopped it -- I'd stopped many a C&R. I had no reason not to.
Q. Can we play from 08:55 -- well, from here is fine, to 09:30, please.
(Video played)
MS SIMCOCK: So Charlie Francis here asks, "Are you going to stop being a tool now? Stop being an idiot?" That was loud and in your hearing, wasn't it?
A. Possibly.
Q. You don't challenge Charlie Francis about that language. Why not?
A. Probably would have washed straight over my head again.
Q. You didn't report him. Again, you should have done,

shouldn't you?
A. Look, in that environment, you work with this day in, day out, and this is a normal working environment, and after a while, you just go in, do your job.
Q. But you weren't doing your job?
A. I was doing my job.
Q. Your job, as a nurse, was to challenge inappropriate behaviour towards this detainee in your safeguarding role as the nurse present, wasn't it?
A. If I'd seen it --
Q. That was your job?
A. If I'd seen it, I would have challenged it. If I'd realised it, I would have challenged it.
Q. At 00:09:09 minutes, D1527 says, "My neck, my neck". You say:
"I do not believe that I heard this comment, or I would have intervened. At this point DCO Paschali's hands are along the sides of D152's jaw and it can be seen that no pressure is being exerted by his thumbs."
In fact, D1527 says "my neck" another three times between 00:09:14 and 00:09:16. Do you agree with that from the footage?
A. Yes.
Q. You're in the cell at this point, as we have just established, to the side of Yan Paschali. You would

have heard that, wouldn't you?
A. That, I don't know. Possibly.
Q. Did that not concern you, that he's been subject to restraint and he's complaining about his neck?
A. Yes, it would have done.
Q. Yet you don't raise any concerns or intervene in any way. You should have done, shouldn't you?
A. I can't intervene until he's calm.
Q. You wouldn't intervene, when a detainee was complaining about their neck during a restraint, to stop the restraint?
A. I thought you said the restraint had stopped?
Q. The restraint had stopped, in your view?
A. No, you just said that, didn't you? Sorry.
Q. He's still being restrained on the floor, isn't he, when he says, "My neck, my neck", five times? Yan Paschali is still kneeling there. We can play it again, if you like?
A. Yes, please, if you could.
Q. Can we go back to about 9 minutes, please.
(Video played)
MS SIMCOCK: He's still being restrained by Yan Paschali around his jaw and neck, isn't he, when he says, "My neck, my neck" five separate times?
A. Okay.

Q. You didn't intervene to stop that. Why not?
A. Maybe I didn't hear it. If I'd heard it, seen it, I would have done. If I was by the door, I wouldn't have noticed or heard it.
Q. Again, is the reason that you haven't mentioned in your statement what Charlie Francis says in your presence loudly that it's derogatory and you failed to challenge it at the time?
A. No, because it would have washed over my head, as I said before.
Q. It is inappropriate to call a detainee a "tool", isn't it?
A. Yes.
Q. It is inappropriate not to challenge that behaviour by other staff members, isn't it?
A. If you're aware of it, but it's day to day. You almost become immune.
Q. So you weren't reporting it when you should have done?
A. But you almost become immune to what's going on there. You just do your job and go away.
Q. So you didn't report it when you should have done; is that right?
A. No, I disagree with that.
Q. In relation to the monitoring role that I have asked you about in relation to the use of force upon D1527,

assuming that it's accepted, what you now say, that you couldn't see the hold by Yan Paschali on D1527's neck and you couldn't hear either what Yan Paschali said to him or D1527 saying, "My neck, my neck", how were you monitoring the use of force upon him?
A. Visually.
Q. But you couldn't see?
A. What I can see. I can only see -- if I'm by the door, I can only see visually.
Q. The monitoring of the use of force by healthcare staff present is an important safeguarding role, isn't it, of the welfare of a vulnerable detainee?
A. Yes.
Q. It's an important protective duty to raise concerns in relation to a restraint because nurses have the power, and indeed obligation, to stop a use of force and say, "A medical emergency. Hands off" and detention staff are expected to comply with that; that's right, isn't it?
A. That's right.
Q. If we are to believe what you now say, that you couldn't see and you couldn't hear, you had a responsibility, didn't you, to put yourself in a position where you were able to see and hear what was going on in this restraint?

A. In a small, chaotic area, you have to be the safest point that you can try and observe. It's not --
Q. It was -- sorry.
A. No, go on.
Q. It was particularly important to be able to see the detainee's face and neck, wasn't it? During a restraint, during force used upon a detainee, where their head is being controlled in the use of force and restraint is being applied, it's particularly important to be able to see their face and neck, isn't it?
A. Yes.
Q. Because how else are you to assess their breathing, for example? You would agree with that?
A. You can assess breathing from the chest.
Q. Isn't it important to be able to see whether anything is obstructing their airway or whether force is being applied inappropriately to someone's neck, given how dangerous that is?
A. Yes.
Q. It is also important to be monitoring their welfare in terms of their levels of distress, isn't it? If you can't see their face, it is more difficult to assess whether they're distressed or not; is that right?
A. It is, but you can't always see.
Q. Well, you didn't put yourself in a position to be able

to see, did you, on what you now say to the inquiry? That's right, isn't it?
A. Because there wasn't another position for me to be in.
Q. And you didn't raise any concerns with the officers, "Look, I can't see. You need to move", or, "I need to be able to get through to be able to see". You didn't raise any concern of that nature?
A. There was nowhere else to move to.
Q. You could have stopped the restraint, "You have to stop the restraint if I can't see and monitor his welfare". You didn't do that, did you?
A. If I'd seen it and noted it, I would have always stopped the restraint.
Q. But what I'm suggesting --
A. I've done that a lot of times.
Q. -- what I'm suggesting is, because you couldn't see, you therefore couldn't fulfil your safeguarding monitoring role and so you should have stopped it in those circumstances, shouldn't you?
A. I'm not going to answer that because I don't recall that incident that clearly.
Q. The safeguards available to him in the form of you monitoring his health and welfare during this restraint completely failed him, didn't they, because you couldn't see or hear what was happening to him; that's right,

isn't it?
A. They wouldn't have been at their best.
Q. Not at their best. Did you ever attend any G4S training on control and restraint at all?
A. Break-away techniques.
Q. Did you ever receive any training on what types of techniques and what level of force was appropriate for the use on vulnerable detainees? Was there any training on that --
A. I don't know. I don't think so.
Q. You don't think so. Did you ever ask to be trained in that regard?
A. I don't know. I can't remember.
Q. How would you have known that force used -- force being used was excessive in order to make the decision to stop the use of force if you weren't familiar with when control and restraint could be used and what level it could be used to?
A. I don't know.
Q. Could we look, then, please, at the same video, from 09:30 to 10:00, please.
(Video played)
MS SIMCOCK: D1527 is forcibly put into the recovery position here. He is clearly in very severe distress here, isn't he?

A. Appears to be, yes.
Q. This is evidently someone who is mentally unwell. That's obvious, isn't it? Yes?
A. Yes.
Q. That didn't concern you at the time sufficient to raise a concern at this stage that the force should cease?
A. I honestly can't remember. I've said, if I'd known and been aware of it, I would have stopped it.
Q. If we look, please, at 12:00 minutes, and if we can play to 12:28, please.
(Video played)
MS SIMCOCK: Just dealing with what you can see and hear here, you see where you are in relation to him. You can hear on the footage what he sounds like. You must have heard this, do you accept?
A. I accept that.
Q. You say, and you say in your statement, that you say, "He needs to go to HMP, back to Belmarsh", and you say that that's because HMP Belmarsh has better facilities than Brook House and it had inpatient healthcare. So you recognised at the time, both that his presentation here was due to underlying mental ill-health, didn't you --
A. I recognised he was unwell.
Q. -- and that that was an indication that you thought his

condition couldn't be adequately managed at Brook House?
A. Absolutely, yeah, yeah.
Q. Did you take any steps to raise that concern about D1527 with anyone?
A. Probably not, because he was already under the care of the RMNs, who were looking after him. He wasn't known to the general healthcare staff.
Q. You were clinical lead?
A. I wasn't at that time.
Q. You were a senior nurse of 38 years' experience. You would have known of the way to raise such concerns. Didn't you consider it was your duty to do so, as the nurse attending this incident and holding that view, that he couldn't adequately be managed in Brook House? Shouldn't you have raised a concern?
A. With hindsight.
Q. D1527, we can hear, continues to cry and scream. What we next here is DCO Francis saying, "We're getting bored now. What are you, a man or a mouse? Stop being a baby. Stop being a baby". We can play it if you would like, but you don't address those comments in your witness statement. Why was that?
A. I don't know. Again, just banter over the head.
Q. They're inappropriate, aren't they?
A. Yes.

Q. And you didn't challenge them at the time. You should have done, shouldn't you?
A. Again, if I'd probably been fully aware of them, yes.
Q. If we play the footage, please, from 27:00 minutes to 27:49.
(Video played)
MS SIMCOCK: This is you talking to DCO Tulley after the incident in the staff room. Do you recognise that?
A. That's not in the staff room.
Q. Sorry, where is it?
A. That's, I think -- if you play it again, I think you'll find that's on E wing.
Q. It's you having a conversation with DCO Tulley about recording the use of force. You say at 27:03 minutes:
"Are they putting that down as a restraint?"
Why did you ask if they were going to put the incident down as a restraint?
A. I just assumed they would be, because it was down to DCO Tulley to do the form.
Q. Was there any doubt that he had been restrained?
A. No.
Q. So why are you asking about it?
A. I don't know.
Q. Because even if nothing inappropriate had been done by Yan Paschali, or indeed anyone else, or if something

inappropriate had been done but not seen by you, there's no question that this is properly described as a restraint, isn't there? This was a restraint?
A. This was a restraint, yes.
Q. So why are you asking if they are going to put it down as a restraint?
A. I don't know.
Q. A use of force form has to be filled in whenever any force or restraint is used. It's mandatory?
A. They do.
Q. Callum Tulley's answer was effectively, "No, it's not as it stands, it's not being recorded as a restraint". That's what you understood him to be saying --
A. And Callum Tulley should have a use of force form.
Q. I'm not asking about who should have done it. I'm asking about what you understood him to be saying. You understood him to be saying, from his answer, that he wasn't going to record it as a restraint, didn't you?
A. Yes.
Q. Did that not concern you?
A. Yes, it would have done.
Q. Why didn't you do anything about that concern?
A. In what way?
Q. Well, what could you have done about that concern at the time, do you consider, as a nurse of 38 years'

experience? You could have said to him, something along the lines of, "But, Callum, it was a restraint, wasn't it?"
A. I could have done.
Q. "And you have to fill the form out, because it's mandatory". You didn't say that, did you?
A. No.
Q. Why not?
A. I don't know.
Q. Don't you have a duty to report that, that he's not going to fulfil his obligation to fill out the form?
A. I don't think so.
Q. Why not?
A. Because it's a DCO role, isn't it? It's not a healthcare role.
Q. But as your NMC standards say, you have a duty to challenge inappropriate behaviour amongst other staff, don't you?
A. Does that relate to all staff or just healthcare staff?
Q. Well, you tell me.
A. I don't know. I don't have any access to NMC Codes or anything now.
Q. In relation to the statement, "I can't write anymore because my hand isn't going to let me", the inquiry initially transcribed that as "Yan's not going to let

me", and we accept that it's "my hand isn't going to let me" and so the transcript has been amended. But that comment about you not writing any more because your hand isn't going to let you was in the context of asking a question about whether officers were recording a restraint and receiving the answer "no", isn't it?
A. No, it isn't, it's because I have arthritis in my hands and my hands were very painful at that time.
Q. Does that indicate that you didn't record as fully as you should have done if you had had an uninjured hand?
A. My ACDT documentation was adequate, as found by the Home Office and by healthcare manager.
Q. You were reading to Callum Tulley from your ACDT entry, weren't you?
A. I was.
Q. And you said, "A T-shirt around his neck, angry and upset. He may have phone battery in his mouth. Attempted to self-strangulate on toilet. Visual observations only due to demeanour. Yeah, that's all I can say, isn't it? It still hasn't been done properly so I don't know."
You say in your witness statement that the comment -- you believe the comment "It still hasn't been done properly" may be a reference to the fact there should have been an incident report and a use of force

form, but you say that's not your responsibility. But we have just established that you didn't say to anyone that they should fulfil their responsibilities in filling out a use of force form, did you?
A. Probably not.
Q. You didn't report to anyone that no use of force form had been filled in by them as required, did you?
A. No, I had my own paperwork to do.
Q. But wasn't that part of your responsibility to D1527?
A. To complete the use of force form? No.
Q. To ensure that you reported inappropriate behaviour by staff in not completing the form?
A. My responsibility was completing the three lots of paperwork I completed for him.
Q. You say, at paragraph 21(e) on page 20 of your statement, that it was open for DCO Tulley to disagree with what you wrote or to seek to add to it on the ACDT.
A. That's right.
Q. But DCOs, you're aware, aren't you, aren't clinically trained?
A. The ACDT is an open document, it is a public document. It's not -- and they are trained in ACDT writing.
Q. Were you aware that DCOs weren't clinically trained, is the question?
A. Yes.

Q. They are not given, or they are only given very limited, mental health awareness training, aren't they? Were you aware of that at the time?
A. No, but ...
Q. Callum Tulley was a young, inexperienced DCO working in activities, and you'd been a nurse for 38 years, and you didn't challenge him when he said he wasn't going to be recording the restraint, did you?
A. No. Probably not.
Q. Are you really saying that you expected him to disagree with what you wanted to put in your entry in the ACDT in those circumstances?
A. No, but I would have expected him, if he'd needed to, to write a comment of his own.
Q. Are you relying upon his lack of challenge to your note for the appropriateness of that note?
A. My note was appropriate.
Q. There's no mention in your entry in the ACDT of a restraint, is there? No mention at all of a use of force?
A. No, but my note has been deemed acceptable.
Q. Do you think that "angry and upset" accurately describes what we have just seen on the footage D1527's condition and presentation in this incident?
A. In a public document, yes.

Q. "Angry and upset"?
A. Yes.
Q. That's what he looks like to you on the footage, is it?
A. If I put anything medically in there, it would be, "Oh, you're writing medical in confidence". It is an open document that you could write in, anybody could write in.
Q. You could have put "severe distress", couldn't you?
A. Possibly.
Q. You say at paragraph 21(d) at page 20:
"The handwritten record was brief, not because I was seeking to cover up the facts but because I was suffering pain in my hand. I suffer from arthritis and fibromyalgia which made writing difficult."
But that's not a legitimate reason to leave out the restraint, is it?
A. I did mention it. I think -- did I not say something about things being moved by officers or something?
Q. "ACDT. Seen in room 7. Constant watch. D1527 had tied a T-shirt around his neck. Angry, upset. Had mobile phone battery in his mouth. Attempted to self-strangulate in toilet. Visual observations only due to demeanour. Resps 16."
No mention at all of a restraint there, is there?
A. No, but it was an adequate ...

Q. You still say that's adequate?
A. I still say that's adequate.
Q. Do you think that adequately reflects his full presentation that we see on the footage?
A. I think it's adequate for what I've written.
Q. Is the pain in your hand the real reason you didn't write a full note?
A. I have arthritis and fibromyalgia. I was under the care of a rheumatologist and just starting medication --
Q. Was that the question --
A. -- so yes, I do have severe pain in my hands.
Q. What I'm asking is a different question, Ms Buss: was pain in your hands the reason you didn't write a full and accurate note?
A. Yes.
Q. It was your responsibility and duty to the patient to do so, though, wasn't it?
A. My notes were accurate. They might have been short, but they were accurate.
Q. Had you raised your inability to do your record keeping adequately, because of the pain in your hand, with your management?
A. Yes.
Q. What was their response?
A. Sent me for an occupational health review.

MS SIMCOCK: That may be a convenient moment for a break, chair. 3.20 pm, please?
THE CHAIR: Thank you very much.
(3.07 pm)
(A short break)
(3.24 pm)
MS SIMCOCK: Could we have on screen <CJS001002> at page 38, please. The bottom half of the page, please.
Ms Buss, this is D1527's medical record. We see there your entry for 15 April, timed at 18:51. The note that you made there:
"Examination: placed on rule 40 constant supervision as he refused to return to E wing. Called to E wing at [approximately] 19:00. Constant watch. Had placed a ligature around his neck. Removed by staff. Staff trying to engage with him. RMN Dalia tried to engage with him with minimal effect. Put mobile phone battery in his mouth which he later removed battery removed from his room. Went to toilet and attempted to self-strangulate. Angry and not engaging with staff. Hands removed from his neck by staff. Salivating + +. Unable to take any observations. Visual obs resps 16. Slight redness noted on his neck. 20:00 got up and walked around room. Taken a small drink. Restless. Constant watch continues. Not engaging with staff.

Plan: please review later this evening."
There's no mention there of a restraint, is there?
A. "Hands removed from his neck by staff".
Q. No mention of a use of force to do so; do you agree?
A. No, but it's self-explanatory, isn't it? His hands have been removed by staff.
Q. So the description that you recorded "Hands removed from his neck by staff", are you saying that that accurately conveys what we see happen on the footage we have just viewed?
A. No.
Q. It doesn't go anywhere near to record the true nature of what happened to D1527 during this incident, does it?
A. No, it could have been fuller, couldn't it?
Q. It entirely minimises the seriousness of the use of force against him, doesn't it?
A. I think my notes could have been better.
Q. Any healthcare staff reading that entry afterwards who was not present at this incident would have been completely unable to understand the full nature of it, wouldn't they? The length of it, for example, that four officers had used a significant level of force on D1527 and the level of his distress. They wouldn't understand any of that from this entry, would they?
A. It could have been fuller.

Q. You record "Salivating + +". How were you able to ascertain that, if you couldn't see his face and neck during the restraint?
A. That would be when he was given a drink, maybe. I don't know. It's five years ago.
Q. You say you could only visually observe D1527 because of his demeanour in your statement. There's no recording of any mental health concern here, given the nature of his demeanour, is there?
A. Apart from the fact he's "Angry and upset".
Q. This was someone --
A. "Angry and not engaging".
Q. -- who had tried to kill himself. He had been incredibly distressed, screaming and crying, as we have seen on the footage, obviously extremely unwell. That note simply doesn't accurately convey that underlying mental health presentation, does it?
A. Could have been fuller.
Q. Dr Oozeerally saw D1527 the next morning, and if we just go over the page to page 39, please, and up to the top, on 26 April, between a third and half the way down the page, do you see Dr Oozeerally -- thank you. That's Dr Oozeerally's entry, when he saw him on E wing, and he says:
"History: seen in E wing. He says he feels well

today and no medical problems. I believe he presented with challenging behaviour overnight but settled and later became co-operative."
Would you agree that that seems to be a note of what was quite a superficial and brief review by Dr Oozeerally of this patient?
A. I can't comment on it. I don't know what the conversation was between Dr Oozeerally and the patient.
Q. Well, all he says is:
"He says he feels well today and no medical problems."
Then he records that he was aware of challenging behaviour overnight. That doesn't indicate an in-depth examination, does it?
A. I don't know what his verbal communication with the detainee would have been, so I can't comment.
Q. Do you think that the doctor would have known to do a more in-depth mental state examination had your note been fuller, as you put it, in terms of his presentation the previous day?
A. I can't comment on what the doctor would know or not know.
Q. Well, all he would know is what's in your record, wouldn't he?
A. He'd know -- I suspect he's probably spoken to him or

maybe the staff on E wing. I don't know. I can't answer that.
Q. In relation to, then, the use of force form, could we please look at <CJS005534> at page 10, please. This is the form that is -- a use of force form that is to record a report of injury to a detainee, and, as you see -- as you have said, this part of the form is blank because the detention staff didn't fill it in. If we go over the page, please, this is the healthcare section, isn't it?
A. Yes.
Q. Section 3. It says:
"Healthcare's report (to be completed by medical staff)."
It has the time and date of examination, 25 April 2017 at 19:00. That would have been the date of the incident, the date and time of the incident?
A. It wouldn't have been the time. The time was later than that.
Q. I see. It should have been the time of the incident or it should have been the time of the examination on the detainee after the incident?
A. I don't know, but we know the time was later.
Q. This is, as we know, Mariola Makucka, another nurse's entry, which you say you caused her to write on your

behalf; is that right?
A. Yes, I would have asked her to do that for me.
Q. Did you approve this entry once she'd done it?
A. No, she would have done it.
Q. Why not, given it records your attendance at this use of force and not hers?
A. She was there part of the time.
Q. But it's an entry on your behalf, that you say you caused her to write?
A. I asked her to write it. She was on the night shift, so she probably wrote it in the evening. I don't know.
Q. If we look at what it says then:
"Seen on E wing room 7 by RGN Jo."
That's you:
"Detainee had placed a ligature around his neck, removed by staff. After this he went to toilet and attempt to self-strangulate. Hands removed from his neck. Slightly redness noted on his neck."
Given this is recorded in a use of force form, I suppose we can at least understand that force was used upon D1527 during this incident. Again, do you accept that this brief note in no way confirms or conveys the seriousness of the incident that we actually see on the footage?
A. I think, again, it could have been fuller.

Q. It didn't meet the standards required of you, did it? Do you accept that?
A. No, I don't. I think it's --
Q. You think this is adequate in conveying what we see on the footage in relation to this incident?
A. In relation to the incident, probably not.
Q. Had we not got the footage of this incident from Callum Tulley's undercover camera, we would have no appreciation from the totality of your documentation in the three records you document in of the true nature and seriousness of this incident, would we?
A. I'm very grateful you have that footage.
Q. As are we. A rule 35(3) report was completed for D1527 by Dr Oozeerally on 13 April, recorded in his medical records. Were you aware of that on the 25th when you attended?
A. No.
Q. Why not, given it is in his medical records?
A. Because he would be part of the mental health team and it wouldn't be common knowledge for everybody to know in the department.
Q. You seemed to know something about him, though, because you knew he'd been at HMP Belmarsh, didn't you?
A. Yes.
Q. Because you say that in the footage.

A. Yes.
Q. Do you think that you had met him before this date?
A. No, I definitely hadn't.
Q. How can you be so sure of that, given your problems with memory from this time?
A. Well, anybody you meet, you document.
Q. You assessed D1527 as suitable for rule 40 removal from association just a couple of hours before the incident with Yan Paschali. Do you remember that?
A. I believe, and I wouldn't be sure, that I was asked to complete that form because I think that form should have been completed 24 hours earlier by somebody else.
Q. Yes. You may be right about that. But do you accept that you did assess him as being suitable for rule 40 removal from association and filled in the form?
A. I probably would have trusted what somebody said to me and said, "Can you complete that?".
Q. So you think that's someone else's assessment and not yours?
A. I would think so, I don't know. It's five years ago, isn't it? I don't know.
Q. In performing that assessment, did you review his medical records for the purposes of filling that form in?
A. Don't know.

Q. If not, why not?
A. I would assume that you trust the people you work with and somebody has asked me to do that, so I've gone and done it, same as I asked Mariola to complete the 213 for me.
Q. But it was important to know his recent history in making that assessment, wasn't it?
A. It would have been, but I would have assumed, as an assumption, that somebody's asked me to complete it, so I've just completed it.
Q. As part of that assessment, suitable for rule 40 removal from association, wouldn't the fact that he claimed to be a victim of torture, and that a GP had agreed he may be, be also relevant? That's a relevant factor, isn't it, to his removal from association under rule 40?
A. I don't know now. It's five years since I've worked with any of these documents. I wouldn't know.
Q. How would you generally carry out assessments that someone was suitable for a rule 40 removal from association at the time?
A. Now, I don't know. As I say, it's five years since I've done this.
Q. Do you think you would have seen the detainee in person in order to make the assessment, or would it be on other information?

A. Maybe both. I don't know.
Q. What was the purpose of the assessment for rule 40 removal from association?
A. As I say, it's five years ago. I haven't looked -- worked with any of these documents. I couldn't tell you.
Q. In relation to rule 35, and in particular rules 35(1) and (2), would you have been aware of those rules at the time in 2017?
A. I would think so.
Q. Do you think you had a full understanding of the different limbs of the rule?
A. I would think so, yes.
Q. You provided training in Brook House on torture awareness, didn't you, which included the need to refer for a rule 35 assessment?
A. Mmm.
Q. You provided that training as part of your documents to the NMC. Do you remember that?
A. I don't think it was documents for the NMC.
Q. They have an NMC -- we have certainly got them from the NMC. Perhaps we can look at them, <NMC000011> at page 6, please?
A. I wouldn't have sent them to the NMC.
Q. That may be right. They may have come from

Sandra Calver.
A. Yes.
Q. This has your name on it, "Torture awareness". Does that look familiar?
A. I would have developed that, yes.
Q. At page 20, please, that includes a reference to assessment under rule 35. Do you agree?
A. Yes.
Q. At page 21, next page on, you deal with rule 35(1):
"Medical practitioner concludes that a person's health is likely to be injuriously affected by continued detention or any conditions of detention."
Does that look familiar?
A. Yes.
Q. Over the page to 22, this is subsection (2):
"To be completed if Dr has concerns that a detainee may have suicidal intentions and the detained person shall be placed under special observations for so long as those suspicions remain ..."
That deals with the first two limbs of rule 35. Do you agree?
A. Yes.
Q. So it seems as though you were familiar with the separate limbs of the rule; indeed, you were training others on them. Is that right?

A. Mmm-hmm.
Q. Did you understand that, even if someone did have a rule 35(3) report as being maybe a victim of torture, that didn't preclude a report later being done under one of these limbs of the rule if the circumstances in them applied?
A. Yes. Yes.
Q. So you could have both, couldn't you: a rule 35(3) report and a rule 35(1) report if you were deteriorating in detention or a rule 35(2) report if you had suicidal intentions? You could have two types of report?
A. I would think so.
Q. It would be important that if someone was deteriorating in their mental health in detention, for a rule 35(1) report to be completed, or at least to be considered, by the GP; do you agree?
A. Yes.
Q. If there was a suspicion by anyone that someone had suicidal intentions, it would be important that a rule 35(2) report was completed, or at least considered, by a GP. Would you agree with that?
A. Yes, but please remember I haven't looked at any of this since -- for five years.
Q. Yes.
A. So this is real memory.

Q. I understand. But the purpose of the rule is to identify to the Home Office someone who -- there are suspicions that they have suicidal intentions. So that's the purpose of the rule 35(2) report?
A. Yes.
Q. If someone was deteriorating or was likely to deteriorate in detention, notifying that to the Home Office is the purpose of rule 35(1); is that right?
A. Yes.
Q. You would have understood that at the time, given you were working with these rules, and, indeed, providing training on them; yes?
A. Yes.
Q. They're important safeguards against the detention of vulnerable detainees. Would you agree?
A. Yes.
Q. A GP is the only person who is able to write the report. You would have been aware of that at the time, wouldn't you?
A. Yes.
Q. There was no doctor present during this incident on 25 April, was there?
A. No.
Q. The mechanism by which a doctor becomes aware that a rule 35 report might be necessary is through a nurse

referral, isn't it?
A. Not always. A doctor can refer and can do. It is not just a nurse that can do.
Q. But if a doctor is not aware of something, they can't report on it, can they? They have to first become aware that one of the circumstances in limbs one or two of this rule is present, and how are they to become aware of it if they are not present during an incident of self-harm or suicide attempt? It is the nurse's obligation to bring it to their attention, isn't it?
A. Yes, but I think here a doctor would have been aware of this man, having read his notes.
Q. You certainly didn't refer this case --
A. No, I didn't.
Q. -- to a GP under rules 35(1) or (2), did you?
A. No.
Q. Why not?
A. I'm assuming -- again, I don't know, but I'm assuming probably because he was under the care of the RMNs that they were looking after his needs.
Q. There's no mention of the necessity for a GP to complete a rule 35 assessment in any of your documentation, is there?
A. No.
Q. In fact, the plan was just "Please review later this

evening", wasn't it? That's inadequate, isn't it?
A. No.
Q. Shouldn't you, as the nurse present and monitoring this incident, have referred him to a GP for a rule 35(1) or rule 35(2) report?
A. What about the other four nurses that were present at times through this?
Q. Well, I'm asking questions of you.
A. Yes, but other nurses were present, including an RMN.
Q. Again, I'm asking questions of you. Why did you not make a referral to a GP under rules 35(1) or 35(2), given your understanding of the rule at the time?
A. I don't know. I can't -- that, I can't tell you.
Q. We know in 2017 there were only eight rule 35(1) reports completed and no rule 35(2) reports at all. Were you aware at the time that those numbers were so low?
A. No. Wouldn't have involved us. We wouldn't have been told about things like that.
Q. Were you referring detainees who had self-harmed or attempted suicide for rule 35 assessments?
A. You refer them to the doctor for the rule 35 assessment.
Q. Were you referring them?
A. If I'd seen them, yes.
Q. Did anyone ever raise with you the absence of reports under rule 35(1) or 35(2)? Did anyone ever raise with

you the absence --
A. Not that I'm aware of. I don't know. I don't think so.
MS SIMCOCK: Thank you. Chair, those are all the questions I have for this witness. Do you have any questions?
Questions from THE CHAIR
THE CHAIR: Thank you. I just have one brief question, Ms Buss. You talk about, in your statement, some of the conditions of working at Brook House, and you have obviously got a lengthy experience of having worked in other similar environments, both at Tinsley and in the Prison Service. Was Brook House different in any way to those other environments and, if so, how?
A. Considerably different.
THE CHAIR: Could you tell me a bit more about how?
A. Tinsley House was very relaxed.
THE CHAIR: I'm sorry, just so the transcriber can hear what you are saying --
A. One or both.
THE CHAIR: That's fine. If you just sit forward so she can hear.
A. Tinsley House was quite relaxed and quite an open atmosphere where you could get to know your clients; smaller numbers. Brook House had very, very large numbers that you never knew and, again, even in comparison to the Prison Service, there was no structure

at Brook House. You were trying to do a job in an incredibly difficult environment with varying levels of support. Some days it was there, some days it wasn't. It was an absolute hellhole to work in.
THE CHAIR: You mention in your statement that you escalate -- "despite escalating the issue". Who did you escalate it to, can you remember?
A. For?
THE CHAIR: That you raised concerns about the environment at Brook House. Can you remember raising concerns with people?
A. Not now. Not now. But I think, generally, you kind of know -- most people know it's not a nice place to be, and for detainees as well. It is not a nice place.
THE CHAIR: Those are all the questions I have. Thank you very much. I know it is not an easy experience, Ms Buss, but I'm very grateful you have come today and I have listened carefully to your evidence.
A. That's all right. Thank you very much.
THE CHAIR: Thank you.
MS SIMCOCK: Chair, before we finish for the afternoon, I neglected at the beginning of Theresa Schleicher's evidence to ask you to adduce both of her statements into evidence in full, they are <BHM000031> and <BHM000032>.

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

I N D E X