Monday, 28 March 2022
(10.00 am)
MS SIMCOCK: Chair, the witness today is Dr Hard.
DR JAMES JESSE HARD (affirmed)
Examination by MS SIMCOCK
MS SIMCOCK: Can you give your full name to the inquiry, please?
A. My name is Dr James Jesse Hard. I'm known to everybody mostly as "Jake".
Q. Thank you. Dr Hard, you have prepared two reports for the purposes of the inquiry. You are the independent medical expert instructed by the inquiry to give your opinion on clinical matters relevant to the terms of reference; is that right?
A. Yes.
Q. Those two reports are at -- the original one at <INQ000075> and the supplemental report at <INQ000112>. I think you have hard copies in front of you, if you wish to refer to them during your evidence.
I would ask that those two reports are adduced in full, chair.
THE CHAIR: Thank you.
MS SIMCOCK: What that means, Doctor, is that I don't intend to deal with every single line in those reports, but to ask you some questions about some of the aspects that

you cover there.
First of all, what qualifications do you hold, please?
A. A Bachelor of Medicine and Surgery from the University College in London 1998, and membership of the Royal College of GPs, which is my GP qualification, I think 2006.
Q. You have worked in various custodial environments; is that right? Mainly prisons?
A. Yes, predominantly prisons, since 2006. In fact, my first job was working in a prison, and I continue to work in prisons, and I have done over the last 15 years.
Q. Just give us some examples of which prisons you have worked in?
A. I have worked in prisons in England and Wales. So my first prison was in Leicester. I worked then in Parc Prison for about six years, which is a private prison in Wales. I have worked in Swansea Prison, Eastwood Park Prison, which is a ladies' prison. Then, most recently, I'm now working in HMP Cardiff.
Q. Do you also hold some other roles? You say you were chair of the Royal College of GPs' Secure Environments Group; is that right?
A. I was until March 10. I have just handed that over to the new chair, Dr Caroline Watson, after six years of

holding that role, for two three-year tenures.
Q. What did that role entail, briefly?
A. Coordinating a UK-wide group membership of GPs working in secure environments -- prisons and immigration removal centres -- and working at a high level with policy and strategy people from, for example, NHS England and Improvement, HMPPS, and PHE, as they were known, and now UKHSA.
Q. You say you are an associate advisor to the Parliamentary and Health Service Ombudsman and provide clinical advice across the general practice, substance misuse, and prison domains. Is that right?
A. Yes. In fact, I have done advice and guidance for all of the ombudsmen across the three areas where ombudsmen are.
Q. You also say you have been a clinical reviewer commissioned by NHS England to assist the prison and probation ombudsmen with death in custody investigations; is that right?
A. Yes, I have done about 15 of those, including one murder and one level 3 clinical review, which is ongoing.
Q. You say you have contributed to the NICE Guideline Development Group for the Physical Health of People in Prisons; is that right?
A. Yes.

Q. What does that involve?
A. The guideline development group involved a team of researchers for NICE, and then, on the other side, a panel of subject matter experts, and I was there as a GP contributing to the development of that guidance.
Q. Do you have any experience of working in immigration removal centres?
A. Not directly, no. I have never worked in an immigration removal centre.
Q. Have you visited Brook House for the purpose of this inquiry?
A. I have, yes.
Q. You were also instructed by the coroner as the independent expert in the inquest into the death of Prince Fosu in Harmondsworth IRC; is that right?
A. That's correct.
Q. Just very briefly, what were the particular issues that arose in that investigation?
A. Prince Kwabena Fosu was a 31-year-old man who died after six days of arriving in Harmondsworth IRC. It was his second visit to the IRC. He died, essentially, of dehydration and self-neglect, likely to have been severely mentally unwell and died within six days of his arrival there.
Q. For the purposes of preparing your reports for the

inquiry, you have read a large number of documents, including the Detention Centre Rules, the various DSOs, including the one on rule 35, the Adults at Risk policy and the statutory guidance and various other policy documents; is that right?

A. Yes.

Q. You have also looked at various contemporaneous documentation from Brook House from the relevant period, I think, such as medical records, ACDT documents and use of force forms; is that right?

A. Yes.

Q. You have also read a large number of witness statements, I think, from, in particular, the GPs working at Brook House and from healthcare staff; is that right?

A. Yes.

Q. And also from formerly detained persons?

A. Yes.

Q. You have read the transcripts of the live evidence of the healthcare staff and also of the witnesses from Freedom from Torture and Medical Justice; is that right?

A. Yes.

Q. Have you watched some of the live evidence as well?

A. Yes.

Q. Who did you watch live in particular?

A. So I've seen Sandra Calver's evidence, I have seen

Dr Oozeerally's evidence and Dr Chaudhary's evidence. I have also seen Theresa Schleicher's evidence and Dr Bingham's evidence.

Q. Do you consider that you have a good understanding of the role of healthcare in an immigration removal centre?

A. Yes.

Q. And also of what was happening on the ground in Brook House in 2017?

A. Yes.

Q. IRCs operate as a different detention environment to prison; would you agree?

A. Yes.

Q. Because, in particular, detainees are not in an IRC by order of a court as a result of a sentence, but, rather, because of an administrative power being exercised by the Home Office; is that right?

A. That's my understanding, yes.

Q. There is no time limit to immigration detention?

A. Not as I understand it.

Q. So that's why, in the context of immigration detention in particular, there are additional rules and policies, such as the Detention Centre Rules, the Adults at Risk policy and the DSOs, which aim to identify people who might be harmed by remaining in detention so that they can be removed from that environment; is that right?

A. Yes, I think so, but I think I would want to add to that that it's also based on my understanding of the nature of the patients that are coming in to the immigration removal that suffer from a number of likely prevailing conditions that also make them particularly at risk. So that's why those safeguards are there.

Q. It is a particularly vulnerable population?

A. Yes.

Q. The role of healthcare, then, in an immigration removal centre is not just to provide primary healthcare to patients, but to provide important clinical safeguards which identify those who are vulnerable to harm in detention and to notify the Home Office of those people so that their detention can be promptly reviewed by the Home Office and that they may be removed from detention unless there are exceptional circumstances to detain them; is that your understanding?

A. Yes.

Q. So notification to the Home Office of a vulnerable person isn't a purely administrative task. It's the role of healthcare professionals to advocate for their patient. Is that your understanding?

A. Yes, and I think -- I mean, I think it is a special additional task that's required, particularly of the GPs with their role, that goes above and beyond what I have

seen, certainly from a prison environment or any other normal primary care environment that I've worked in.

Q. Yes, it's very particular to immigration removal centres?

A. Yes.

Q. Notifying the Home Office is an important patient safeguarding role for an IRC doctor, and indeed healthcare staff, because that role is informing the Home Office of vulnerabilities which mean that there is a risk they might be harmed by detention; is that right?

A. Yes.

Q. That role isn't a one-off at the outset of detention; it remains a continuing role and obligation for as long as the person is detained; is that your understanding?

A. Absolutely, yes.

Q. Would you agree that it would be reasonable to expect a healthcare professional to use all of the available tools at his or her disposal to inform the Home Office about a patient who is particularly vulnerable to harm if he remains in detention?

A. Yes, and I would go further to say that they would need to have a very good understanding of what those rules are and what the purposes of those are in order to be able to do that effectively.

Q. I want to look, then, at some of those rules and

safeguards. If we look, first, at a detainee's arrival into an immigration removal centre, there is a reception health screening process that occurs as soon as someone arrives into an immigration removal centre; is that right?

A. Yes.

Q. There are two stages to the clinical health screening carried out in an IRC on a detainee's arrival. The first is by a nurse, which should take place within two hours of their arrival; is that right?

A. Yes.

Q. The second is then an appointment with a GP, which should take place within 24 hours of arrival. Is that your understanding?

A. I have come to understand that. I don't think I understood it as clearly as that when I first got involved in this particular work and when I wrote my first report, but I have a clear understanding of that particular mechanism and the value of that, having watched some of the evidence over the last few days. So I think that probably needs further understanding and exploration generally.

Q. Yes. It is difficult to understand simply from the face of the rules?

A. Yes, and I think -- I guess what I'm saying is that,

example, immediate risks may include overt plans to self-harm or act on suicidal plans, prescribing of medication that, if missed, could lead to significant health consequences, for example, anti-epileptic medication, or the acute management of drug and/or alcohol withdrawal. So certainly one purpose of the appointment with a GP within 24 hours would be to highlight any immediate health issues that need to be addressed for the patient's safety and well-being; is that right?

A. Yes. I think -- I mean, in particular reference to this paragraph, I'm focusing here on the nursing assessment in order to be able to highlight the specific possible risks to the GP for their further assessment the following day. So that's one component of it.

Q. Yes. You say in your supplemental report at page 56 that rule 34 is inherently important for the early identification of ongoing health needs of an individual on arrival in a place of detention and is crucial for the planning of the detained person's care whilst in Brook House or any other secure or detained setting; is that right?

A. Yes.

Q. So it's important for identification of health needs in order for them to be appropriately addressed through

having reviewed the material before the oral evidence, it wasn't actually clear from the clinical records what was actually happening with regard to the GP's assessment of rule 34.

Q. We will perhaps come to that in a bit more detail in a moment.

A. Yes.

Q. So the appointment within 24 hours, your understanding now is that that's required by rule 34 of the Detention Centre Rules; is that right?

A. Yes.

Q. If we just look then at the rule, if we could have on screen, please, <CJS006120>. Here we see the Detention Centre Rules' front page. If we could go to page 11, please, there we see rule 34, which says:

"Every detained person shall be given a physical and mental examination by the medical practitioner (or another registered medical practitioner in accordance with rules 33 ...) within 24 hours of his admission to the detention centre."

You say at paragraph 6.2.2.4 of your original report that the primary focus of the screening process is to highlight any health issues that may place a person at risk in the early days in custody if steps are not taken to address these, and you give some examples. For

treatment or other referral?

A. Yes.

Q. There is, though, the second very important purpose of rule 34, which is the clinical safeguarding role, which we have looked at briefly, and that functions to identify the need for a rule 35 report, doesn't it?

A. I would agree, yes.

Q. So the absence of any compliant examination under rule 34 means that an important piece of clinical evidence relevant to the consideration of decision making concerning the exercise of detention powers is missing; would you agree with that?

A. I think the timeliness of the rule 34 component is essential, given that there is, to my understanding, not very much done pre-detention to identify people who may be at risk of being in detention. So, as you say, if this component of rule 34 is not undertaken at the earliest outset, then it is going to lead to further delays in the detection of that deterioration.

Q. So rule 34 is not just for a purpose of identifying health needs and addressing them in detention; it's the first opportunity to identify vulnerabilities and risk factors leading to likely harm if detained?

A. Yes.

Q. A rule 35 report can, and should be, completed and

notified to the Home Office at the end of a rule 34 examination so detention can be reviewed at that very early stage if a rule 35 report is appropriate?
A. That's my understanding, yes.
Q. So, in that way, the two rules, rules 34 and 35, are designed to work together as the safeguard?
A. At this point in time, yes. Yes.
Q. It is particularly important, as you have said, at the outset -- that that safeguard is operating at the outset of detention, and that's because of the possibility of harm eventuating if it doesn't; is that right?
A. Yes.
Q. So it is essentially the first opportunity to prevent the exposure to a risk of harm of a vulnerable detainee?
A. Yes.
Q. From the evidence that we have heard and you have now considered, it seems that there were a number of different types of deficiencies in the way that the rules were operating on the ground in the relevant period, and indeed still today; is that right?
A. Yes.
Q. I'd just like to look at some of those with you, then, in a little more detail and see what your view is on them.
We heard some evidence that the nursing screen that

we have referred to, which is the first opportunity that screening is done within -- should be within two hours of arrival, was sometimes really the only appointment which occurred, and so was effectively being treated as the rule 34 appointment. Would you agree with that?
A. That appears to be the case, yes.
Q. That nursing screen is clearly not a full mental and physical examination, as required by the rule; it is a more basic questioning process, sometimes described as a tick-box exercise?
A. Yes. I think -- I mean, it does, in the sort of purist physical and mental health sense, tick some boxes, as you say, in terms of identifying the commonly believed needs of a group of people coming into a secure setting, but it doesn't take the additional step of understanding what -- or going further to explore those specific needs of the detainees when they are coming into that environment --
Q. Yes.
A. -- because of the risk of harm. So it seems to me that the purpose of the rule 35 is not well understood by the people that are undertaking the screen, both at the nursing level and then, subsequently, the GP appointment.
Q. The nursing screen also can't fulfil the requirements of

rule 34, as the rule requires an examination by a medical practitioner or GP?
A. Indeed, yes.
Q. So if it is being treated as the rule 34 appointment, that's in breach of the rule?
A. That would be my understanding, yes.
Q. We heard some evidence that GP appointments are also not always -- indeed, perhaps not often -- done within 24 hours of a detainee's arrival in the centre, in breach of the rule. Is that your understanding as well?
A. That's my understanding of having seen the oral evidence, yes.
Q. Detainees are entitled to refuse the rule 34 appointment. It is to be done by consent. Is that right?
A. Yes. So, yes, somebody would have to consent to the nursing screening as well as the rule 34 appointment with the GP. I haven't seen anything so far that explains what is advised of the detainee of the purpose of those subsequent appointments or the potential appointment with the GP the following day.
Q. It seems that there's some evidence that it's just not being explained to them, the purpose of a rule 34 appointment. Is that your understanding?
A. It is, and I don't wish to say that it's the detained

person's responsibility for that, but I do think it's the healthcare provider's responsibility to explain the importance of attending that appointment.
Q. Yes. Not just to identify any health needs they have in order to treat them or to address those needs, but that very important clinical safeguarding role of that appointment, that's what should be being explained to them; is that right?
A. Yes, I think so.
Q. Because, otherwise, of course, it can't be an informed refusal to attend the appointment?
A. I agree, yes.
Q. Dr Oozeerally and Sandra Calver, as the head of healthcare, 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 the 24 hours of arrival at the IRC. Instead, the practice appears to have been that a second assessment appointment was booked if something was flagged initially through the screening process or in that appointment, sometimes booked after a considerable delay. So the safeguard, in those circumstances, isn't operating at the outset of detention, is it?
A. No, and I think it subsequently leads to delays in the detection of those vulnerabilities and it feels to me

a little bit like the priorities are somewhat misaligned here, because, obviously, the priorities, in my view, would be the safeguarding rather than delaying it. Dealing with that first would be my priority if I was in that position.

Q. Dr Bingham gave some evidence that that process of that practice of booking that second appointment with some delay afterwards was inappropriate because the whole purpose, as we have discussed, of the two rules is that they work together to identify people immediately and route them out of detention. So if, instead, there is a period of delay, a waiting period, as she put it, that means people may deteriorate in the meantime. Would you agree with that?

A. Yes, absolutely. I think there is what appears to be a conflict between the delivery of the primary health services and the delivery of the safeguarding processes, and, as I say, it appears to me that the priority is given to the primary care services rather than the safeguarding aspects of these rules.

Q. One might understand that part of the reason for that is that the delivery of primary care services is something that nurses and GPs understand very well, whereas this is something extra that is clearly not well understood?

A. Yes. I think -- and so, obviously, over a very long

period of time, I think that has been the case, from my understanding so far and all of the things that I've looked at, that that priority going forwards needs to be readjusted so that the safeguarding measures are the priority, in a way. Now, that obviously has significant implications for resourcing, et cetera, but, ultimately, if the safeguarding components aren't effectively dealt with, then there are going to be delays, as you have rightly said.

Q. And harm caused as a result?

A. And harm caused potentially, yes.

Q. We heard from Sandra Calver that GP appointments within the first 24 hours at the time in the relevant period were five minutes long and are now ten minutes long and that that's not enough time to do a rule 34-compliant medical examination. Would you agree with that?

A. I can't possibly imagine how you would undertake to evaluate somebody's levels of risks thoroughly in ten minutes, and I -- I mean, when I heard that, I questioned in my mind whether that's a 10-minute ledger appointment, ie, a place holder, or whether it was actually 10 minutes' worth of time allocated to that. We have also heard, in terms of the length of time that it takes to do a thorough report from subject matter experts being, you know, a considerable number of

hours. So I can see that 10 minutes, even from the outset, isn't enough to do much more than --

Q. Ask if they are okay?

A. -- a very, very cursory assessment.

Q. So five, or indeed ten, minutes certainly isn't adequate to carry out a full mental and physical examination in accordance with rule 34?

A. Unless, at that point, the person said, "There is nothing for you to worry about". If there was anything to be exposed at that point, then it would take a lot more than ten minutes to get to the bottom of it.

Q. Dr Oozeerally said it wasn't possible to do the sort of physical and mental state examination required at this initial GP appointment. He described it as "it's almost like triage". Is that, in your view, to your understanding, what was effectively happening at that stage?

A. It would appear so. I think if you're going to triage, I guess that's the point I was making earlier about where the priorities lie. I think, even if you did have, for the purposes of planning your day, a moment to triage a number of people that had come in the day before, you would then need to allocate some time the same day, in my view, in order to undertake that thorough assessment which, as I said, I appreciate has

implications for the resourcing and the planning of how you deliver your healthcare services. But nonetheless if you triage and then say, "Well, I haven't got an appointment for two weeks", that, to me, is a significant delay that leads to potential harm.

Q. So that evidence essentially shows that the arrangements at Brook House made it impossible to comply with rule 34, the requirements of rule 34, and indeed rule 35, during the relevant period and, indeed, the same today?

A. As I understand it, yes.

Q. That certainly accords with Medical Justice's experience as well; is that your understanding?

A. That's my understanding, yes.

Q. Where, then, that initial screening has detected any factors that indicate an Adult at Risk, the person is likely to be at risk of harm from their detention and shouldn't be in detention unless there are exceptional circumstances, but they are remaining in detention for that period of delay, at least, aren't they?

A. Yes, and, again, I go back to the point that, arguably, if some of this information could be gathered pre detention then we wouldn't necessarily -- or those patients, those detained persons, wouldn't be in that position in the first place. I think that's essential

to consider. Nonetheless, the system as it currently stands, the detained person arrives in detention, those safeguarding mechanisms, because of the prevailing health issues that we understand about them, need to be the priority.

Q. And they are not, so far as we can see from the evidence. That's a serious concern --

A. Yes.

Q. -- that needs to be addressed?

A. Yes.

Q. Again, the reason it's such a serious concern is that that failure means those detainees are being directly exposed to risks of harm and actual harm in detention?

A. Yes.

Q. A different further deficiency identified by the evidence seems to be that, even where the nurses' screening identified certainly vulnerabilities, such as, for example, a disclosure by a detainee that they had been a victim of torture, that wasn't always leading to either a rule 34 appointment with a GP or a further rule 35 assessment and report completed by a GP. Is that your understanding?

A. Yes.

Q. Again, a very significant concern?

A. Absolutely.

Q. Because, for example, if a nurse was told, "I've been a victim of torture", that should be leading to consideration of the rule 35 report --

A. I completely agree.

Q. -- under rule 35(3)?

A. Yes.

Q. A practice seems to have developed, would you agree, that it was up to a detained person to ask for a rule 35 report to be completed?

A. That certainly seemed to be the case with a number of detained persons' records that I looked at, and it seemed to be by request rather than, you know, the clinical healthcare team actively pursuing and ensuring that those safety mechanisms were being utilised at the first available opportunity.

Q. Yes. It wasn't their obligation to ask; it was the obligation of healthcare to identify and carry out their duties under the rules?

A. Yes.

Q. I just want to look at, briefly, a document -- a G4S document that was in place at the time. If we could show, please, <CJS006045> on screen, please. This is the detainee reception and departures G4S policy in place at the time in the relevant period. If we could look at page 21, please. Then if we could just go to

the middle -- so if we -- you can leave it there, thank you. But if, Doctor, we look at the bottom -- towards the bottom of the screen, do you see a paragraph there under the rule which says:

"Detainees who have been seen by the triage nurse and require (or request) to see a doctor, (subject to their consent), will be seen on his/her next visit. Detainees will see a doctor in any such event within 24 hours of admission. There is also provision for a more immediate response from the doctor (at the request of the senior nurse on duty) if clinically indicated."

That, again, seems to suggest that a detained person will see a doctor within 24 hours, firstly, if the nurse thinks they need to, if the nurse thinks they require it; or, secondly, if they request it. Would you agree?

A. Yes.

Q. Which clearly doesn't, as we have just been through, accurately reflect the rule that every detained person shall see the doctor within 24 hours?

A. No.

Q. So that makes this G4S policy inadequate at the time; would you agree?

A. I think that the following of the rule is what is inadequate, or the failure to follow the rule is what is

inadequate.

Q. And this policy encourages that failure?

A. Yes, and I think, again, it sort of underlines the fact that the understanding of why these rules are here in the first place seems to historically have been lost along the way.

Q. Yes.

A. So people don't, at the healthcare end, seem to know what they're doing, why they're doing it, on each point of contact with the detained person.

Q. I want to come on, then, to look at rule 35 itself in some more detail. Can we first deal with training?

A. Yes.

Q. You mention in your original report -- I can give you the references, if you need them, but perhaps let's see if we don't need to turn to it, first of all. There is no specific training regarding the identification of victims of torture in medical school or in a GP's vocational training, is there?

A. Not that I've -- well, I haven't been in GP training for a very long time, but there certainly wasn't any exposure to anything like that when I was in GP training or a medical student.

Q. You wouldn't necessarily expect there to be because it is quite a specific area, isn't it?

A. Yes.
Q. But if someone is working as a GP in an immigration removal centre where that type of population is very prevalent, you would expect there to be some training for them specifically in relation to this area?
A. In my experience, and having expect a fair bit of time talking to GP trainees and medical students alike, you tend to find there are some enthusiastic people who will come and shadow or even do an elective, as I had recently in HMP Cardiff, for a couple of weeks, to expose themselves to that environment because they are interested in the patient group, but it is not something that's delivered to everybody.
Q. No. Nor indeed everybody who works in a particular type of setting?
A. No.
Q. There seems to be a lack of availability of training in this type of area?
A. Yes.
Q. We heard that organisations such as Freedom from Torture have provided some training. Of course, they are charitable organisations. Who, in your view, should be providing training on this type of area to those who are working in IRCs?
A. Well, ultimately, I think it's the responsibility of

the Home Office. But I appreciate that, when I say that, they're not necessarily medically led, from what I understand or what I can see. So I think, if they were to be responsible for that training, it would need to have the support of subject matter experts, clinical experts, who can help deliver that training, speaking, if you like, doctor to doctor, doctor to nurse, and those other people who are doing the work at the immigration removal centre so that they can fully understand the implications of all of the different components of the training.
Q. If we look at, please, <HOM002581> on screen, this is effectively a slide. It is a PowerPoint presentation for GP training, dated October 2015, on Detention Centre Rule 35. I think you looked at this in order to prepare your reports. If we just flick through it, perhaps, briefly, if we can go through, it was clearly provided by the Home Office, as indeed the logo at the bottom suggests, and those people were involved in the provision of it. If we carry on through, please, it deals with, then, the three limbs of rule 35 -- over the page, please -- and it deals with the DSO, which contains the templates for recording, completing rule 35 reports. Was that your understanding?
A. Yes.

Q. Going through, then, it outlines the purpose of the rule, as we see on screen, "to ensure that particularly vulnerable detainees are brought to the attention of Home Office caseworkers with direct responsibility for authorising, maintaining and reviewing detention". If we carry on, please, it deals with the Home Office policy "that persons with independent evidence of torture are normally regarded as unsuitable for detention other than in very exceptional circumstances".
Then it deals with rule 35(3), the limb of the rule dealing with where someone has evidence or has made a disclosure that they may have been a victim of torture in the past.
It seems, then, thereafter, to focus very much on rule 35(3). Would you agree?
A. Yes.
Q. It covers, as we saw at the beginning, very briefly the three limbs of the rule, but then the rest of the presentation is really only on rule 35(3). Is that adequate, in your view?
A. Well, obviously I wasn't there at the presentation, so I don't know what was said verbally. But I think the three limbs need to be taken in the round. They need to be taken together and collectively. And a focus on just

one of the limbs isn't sufficient. It doesn't create the level of safeguarding that I think was originally intended by the rules.
Q. The training doesn't cover the interaction with ACDT or food and fluid refusal. Is that an omission, in your view?
A. Unless it was said verbally -- it's certainly not indicated on the slides that it was discussed -- then I absolutely feel that all of those things that you have mentioned, and no doubt some other things, interact, or should interact, with the three limbs of the rules as they come up.
Q. Including perhaps the use of force to prevent self-harm or suicide attempt?
A. Absolutely.
Q. You say in your original report at paragraph 6.1.3.5 that there is no evidence of a comprehensive approach to the induction and training of these staff prior to the commencement of their work in Brook House; is that right?
A. I have seen evidence of induction. It doesn't seem to go to the level of detail that would appear to be necessary for the safeguarding of detained persons in relation specifically around rule 34/rule 35 and where those things should interact with these other things

that may happen along a detained person's journey, as you have just mentioned.

Q. So there should be, in your view, a more comprehensive approach to the induction and training of these staff in that regard?

A. Yes.

Q. You came to the conclusion in your first report, and indeed in your supplemental report, that there was evidence of inadequate training of healthcare staff. Does that remain your view, having seen all the other evidence?

A. Yes.

Q. There, effectively, was a lack of policy, as you say, in your reports. What policies in particular would you have expected to see that you didn't?

A. Well, I think particularly around rule 34 and rule 35. If I was in a position of responsibility, I would want to make sure that my staff understood why they're doing a particular task and what the outputs of that are, in order to ensure that they were being followed through, and you would need a policy to explain that, rather than just saying you're going to do a screening within two hours and you're going to book an appointment with the GP, you would need to have policies to explain what to do at each point. So, in other words, if you discover

at the -- within two-hours' screening by the nurse that somebody has declared that they have a history of being tortured, then you know that you are referring them to the GP to be seen in order to consider rule 35(3) and potentially rule 35(1) or (2) if there are other issues that are arising from that, and I've seen nothing that explains it with that level of clarity.

Q. You commented also that where there were policies, they weren't supported by bespoke training. Is that what we have discussed, that the training on rule 35 just wasn't sufficiently clear?

A. It wasn't sufficiently clear and I recognise, you know, in -- recruitment and retention in immigration removal centres -- and prisons, for that matter -- is very difficult and you get a high number of staff turnover. So, over time, you can lose an understanding of certain things and why you're doing it. So I think ongoing training, refresher training and a collective understanding is essential in order not to lose the underlying purpose of these particular tasks.

Q. You also commented that, where there was bespoke training, it wasn't provided regularly enough; is that right? Does that also relate to rule 35?

A. It doesn't appear to be, yes.

Q. So there was limited training, limited people received

it on a fairly ad hoc basis, and it wasn't recurring. All of those serious deficiencies?

A. What appears to be a lack of understanding about it all in general, in the round. I think, from what I've seen so far, if we -- if there is a lack of understanding, it's impossible to train or create the policies or, you know, effectively take into account the relevant safeguards that you're trying to pursue.

Q. So the GPs who were working in Brook House in 2017, and indeed now, have received inadequate training, in your view, on rule 35 and the Adults at Risk policy, in terms of being able to carry out their obligations?

A. They appear to have an inadequate understanding of those rules.

Q. In those circumstances, is it appropriate that those GPs are training other GPs in --

A. No.

Q. -- how to do rule 35 reports?

A. No.

Q. We will come to it in more detail later, but you have also concluded that, in the relevant period, around three-quarters of the rule 35 reports that you have seen were inadequate, for one reason or another. Is that right?

A. Yes.

Q. Those were carried out by Dr Oozeerally and Dr Chaudhary and still working in Brook House at the moment and training other GPs in how to do rule 35 reports. Is that, of itself, a serious concern?

A. Yes.

Q. You say, at paragraph 6.2.4.5 of your original report, that in relation to rule 35(3) reports, which were predominantly the reports carried out in 2017 and indeed thereafter, the section 6, which is the conclusions section, the assessment of impact of ongoing detention there is difficult in the absence of specific training. We have dealt with the fact that there wasn't particularly specific training about that. What in particular makes that assessment difficult in the absence of training?

A. Again, it goes back to understanding what is the reason for relaying this information to the Home Office. In fact, it appears that the priority around section 6 within rule 35(3) reports focused on the -- I guess the presence of torture and the history that had been provided, rather than the impact of detention. So almost all of the reports that I viewed during the relevance period made no comment in regard to ongoing detention, when it clearly asks for that specifically. I can understand from the Home Office's perspective that

they would want to see that particular information, because they're considering review of detention based on the rule 35(3) being provided to them at that point in time.

Q. You also mention in relation to other types of training, for example, that compassion fatigue and desensitisation is common in a secure setting, and it is difficult to eradicate. We have not seen any evidence demonstrating a proactive approach to training addressing those issues; is that right?

A. No, and I'm not an expert in the area, but, unfortunately, I have lived and breathed it over the last 15 years in the prison environment, and it is all too easy to become desensitised to some pretty shocking things that you see on a regular basis. So over that period of time, you need to keep your clinical acumen up and your awareness around and your ability to relate to patients at its top level because you're dealing with such complexity.

Q. You haven't seen any evidence of such training or support in relation to Brook House?

A. No.

Q. You make some recommendations about training in your reports, and you say, for example, that trauma-informed care training for both custodial and healthcare staff

would be beneficial for raising awareness from the perspective of detained persons and help to provide a better understanding of their needs; is that right?

A. Yes.

Q. That's particularly so in a population where trauma -- past trauma is particularly prevalent?

A. Absolutely.

Q. In relation to policies, then, you say that the suite of healthcare policies that you were provided with in place during the relevant period appeared to be relatively basic, and you weren't able to identify a system for their regular review and revision. There needs to be an appropriately resourced mechanism by which policies in place are periodically reviewed and updated, and, where appropriate, new policies are developed; is that right?

A. Yes.

Q. You also say it is essential to ensure that healthcare staff are routinely provided with sufficient time and resource for the improved education and training in respect of the awareness of, and use of, both extant and new policies. Did there seem to be sufficient time and resource dedicated to that in Brook House?

A. Not that I've seen, and I think the key here is that policies need to be updated in line with things that we learn, whether guidance changes or we learn from

significant events, and, you know, much of this inquiry is arguably focused on significant events, but I haven't seen any learning as a consequence of those things or updates in regard to the policies and learning that's been acquired for the team's perspective in response to those things.

Q. You also say it is essential that new staff are provided with an appropriate period of induction in order to be familiar with the relevant policies and procedures in place?

A. Provided it's given by people with a good understanding.

Q. Yes, and the policies themselves are adequate?

A. Yes.

Q. I just want to look then at some specifics about rule 35. So in respect of rule 35, Dr Oozeerally gave some evidence that, during the relevant period allocation for rule 35 assessments were one appointment a day. Is that adequate, in your view?

A. Well, I don't know the volume of people coming through on a daily basis. I appreciate it would probably be quite variable and there may be times when there are lots of people coming through, but to allocate one appointment per day does seem on the low side to me, especially if -- you know, if you had two people who came in the night before who had particular needs, then

how do you prioritise one over another? What do you do about other clinical duties and how do you defer or deflect those so you can deal with the primary issue here about safeguarding a particular person's needs?

Q. If there is a need for more than one person to have a rule 35 assessment in a day, it effectively means that there will be delays in everyone else's?

A. Yes, or delays to other components of the healthcare provision, whether that be, you know, seeing the -- it could be anything that you could be seeing as a GP in an immigration removal, and I can imagine, from a GP's perspective, it might range to anything from mental health to physical health, acute things and long-term conditions as well. So I can see the conflict and, having listened to Dr Oozeerally's evidence, I can see the conflict between providing the safeguarding priority over the primary care delivery, but, as I say, I think the emphasis is misplaced here, that actually the safeguarding mechanism should take priority, as I said earlier.

Q. Yes, and they weren't, which was leading to those delays in those assessments?

A. Yes.

Q. While the person who has had the delay remains in detention because they haven't been assessed as they

should, partly because, if one appointment only is being offered a day, which appears to be a resourcing issue, the Home Office hasn't had a chance to review their detention and they therefore remain in detention and exposed to likely harm; is that right?

A. Yes, and I suppose, from the Home Office's perspective, it must feel, you know, a little bit, out of sight, out of mind. They are not aware of anything at that particular point in time so they're not necessarily going to be worried on behalf of that detained person. So until they get that notification formally to say, "Please review the detention of this person based on rule 35(1), (2) or (3)", then they are not going to seek it out because they don't have any mechanism for doing that.

Q. So it is the system that's been arranged which leads to those delays in identifying them and those safeguards failing?

A. Yes.

Q. Can we look, then, specifically at rule 35(3) reports and the deficiencies identified in those, because they really are the only reports that were effectively being created.

A. Yes.

Q. The majority of them, as you have already confirmed, in

the relevant period were inadequately completed, in your view, and I think there were several reasons for that; is that right?

A. Yes.

Q. So there was sometimes a failure to identify mental health consequences of torture, or failure to identify mental health symptoms; is that right?

A. I think it focused too much on -- specifically on torture and whether or not what was being relayed to the GP was torture or not or something else. I think it completely overlooked the fact that you have somebody relaying to you something really quite significant that has happened to them in the vast majority of the rule 35(3) reports that I have seen that might, in itself, simply be a red flag to that person remaining in detention, full stop.

Q. Was there a tendency to focus upon physical evidence of torture, such as scars and completing a body map?

A. I did see evidence and an understanding that not all forms of torture would necessarily lead to scarring. I did see evidence of a physical description of some scarring, but it was certainly, in my view, not done in an expert manner, and I'm not an expert in this area, but I have worked alongside experts who do know how to look at injuries and relate them to the history that's

been provided in relation to that in the work that I've done with the CPT. So I have an understanding of how it's done. I'm not an expert in that area. My humble opinion, on the basis of the rule 35(3) reports that I've seen, is that there is an inadequate relationship between the history that's been provided and the evidence that's then being accounted for in the examination.

Q. In particular, sometimes there was simply no mention of mental health symptoms at all?

A. Indeed.

Q. And the mental health section effectively left blank?

A. Yes.

Q. There was also, on occasions, a failure to address the impact of detention, even though the form directs the GP to do so?

A. Yes. As I have said, I think that was about three-quarters of the reports I looked at didn't mention that at all.

Q. We will come to that, perhaps, in a little more detail in a moment, but if mental health symptoms or mental health is not addressed at all, even in the presence of a history given of being a victim of torture, the result can be that the Home Office relies upon the absence of those concerns being raised from healthcare about those

mental health symptoms as being -- as one of the key factors in maintaining detention. So the negative is relied upon --

A. Yes.

Q. -- in order to continue detention?

A. Yes. That would appear to be one of the factors, yes.

Q. That occurs even in the presence of an acceptance that there is evidence of the person being a victim of torture and, therefore, being a level 2 Adult at Risk; is that right?

A. Indeed, yes.

Q. So the task of -- and this type of assessment, although it's only raising concerns, it is more than about simply documenting the physical; it's very important to address those mental health consequences of being a victim of torture?

A. Yes, and I can see a conflict here, both in terms of what I've seen in the records and in the oral evidence that I've seen from the GPs, that it appears that there is a -- I guess a divergence between mental health in its broadest sense versus severe, enduring mental health, and, in a way, it appears that the GP's perspective is that it's more towards the severe, enduring mental health and, therefore, if you happen to have, you know, a low level -- let's say low-level minor

anxiety or depression or an undiagnosed post-traumatic stress disorder, that doesn't qualify in some way.
Q. We know those conditions with very prevalent in the IRC's population?
A. Very prevalent.
Q. Particularly amongst victims of torture?
A. Yes.
Q. So relying upon the absence of, for example, severe, enduring mental illness, such as psychotic illness, doesn't address those concerns, does it?
A. No, and it doesn't relay the risk to the Home Office that actually somebody has a known issue --
Q. Yes.
A. -- no matter how minor.
Q. Because psychotic symptoms aren't a core diagnostic of or features of PTSD, depression and anxiety, but, as we have said, those conditions are very prevalent in the IRC population?
A. Yes.
Q. So an absence of that type of psychotic symptoms or severe enduring mental health can't be taken as an indicator that harm is less likely in detention, can it?
A. No, and I can see the conflict in the GP's mind. As a GP, I have looked after people, both inside and outside of prison, with a huge variety of different

mental health issues, whether it be, you know, something simple and more common, like anxiety and depression that we manage in primary care, versus those people who I think are acutely unwell and need referral to a specialist team. Equally, when those people have been referred for their bipolar disorder or their psychosis and they come back to me, I'm still responsible for looking after them. So I can see where there may be a divergence there in the GP's mind: "Well, this is something I see outside and, therefore, I can manage it in here" as not being necessarily something they want to report or advise the Home Office of its presence.
Q. Even though they should be?
A. Even though they should be, yes.
Q. You identified that there didn't seem to be any system of feedback or review in relation to reports that were completed; is that right?
A. From the Home Office?
Q. From the Home Office.
A. Yes, absolutely. I would have expected to see something around the quality assurance and, indeed, I didn't find anything, apart from in Shaw's reports, that really talked about this in any detail, in terms of numbers and, you know, what the outcome for those reports was. So I was quite surprised by that, really.

Q. There should be?
A. Yes, I think so, absolutely.
Q. It is important that it is systemic as opposed to individual caseworkers obtaining -- receiving individual reports, coming to their own conclusion that they're not adequate and simply ad hoc informally going back to the IRC and saying, "Well, what about this"?
A. So, again, I think the key here would be in around -- and I don't wish any disrespect to the caseworkers in the Home Office, but if they are not medically qualified or trained, how can they challenge the information that's in there? They can certainly ask for more information.
Q. Yes, they could identify, I suppose, where, for example, something hasn't been even mentioned, such as mental health consequences of being a victim of torture or the impact of detention, but there didn't seem to be any system for doing so. It would only have been ad hoc?
A. Yes, yes.
Q. We know detention was indeed maintained, given the Home Office's reliance upon the absence of such recording, suggesting that even on an ad hoc basis they weren't going back to challenge the absence of that information?
A. Correct.

Q. There's clearly, then, if there's no system for feedback and review, no identification of training needs or the reasons for inadequate responses, is there?
A. No.
Q. And there should be?
A. Absolutely. It seems that the system that's in place, and having listened to the oral evidence, has taken its own trajectory and come to its own conclusion in terms of how it's managed, and that seems to be a fairly unilateral position rather than something that's been guided by feedback -- a feedback process or a quality assurance process.
Q. We have touched upon the failure to consider the impact of detention, which you said was present in around three-quarters of the rule 35(3) reports that you looked at from the relevant period. So, in those reports, the doctor had generally not conveyed any understanding of how past history of torture exposes a detained person to risk of harm or deterioration in detention; is that right?
A. Yes. I mean, the only other thing I would say is, if you're filling in a rule 35(3) report and the person has had a history of torture, that in itself should also bring about a review of detention in and of itself. Whether or not the person -- the detained person is

being managed in the detention setting or is coping in the detention setting really shouldn't be taken into account, in a way. I mean, it may be some reassurance to the Home Office temporarily, but it shouldn't be -- I'm trying to think of the right word here -- a permission to continue detention indeterminately, and, as we have heard, it is indeterminate at the moment, in that sense.

Q. Because there is an understanding from the research and literature on the subject that victims of torture are particularly vulnerable --

A. Yes.

Q. -- to suffering from harm in detention?

A. Yes. Sorry, just to go back to that point, I think I can appreciate, from the Home Office's perspective, if you receive some information saying, "This person has been a victim of torture", you may need to go away, I appreciate, and do other things and that may take some time. But if you haven't been given all of the information or you have been, in effect, reassured by the absence of information or reassured by the fact that the person is being managed in detention, then it seems to take -- it takes the pressure off them.

Q. Yes.

A. In terms of reviewing that detention. That's how it

seems to be to me.

Q. And the Home Office were relying upon those factors to maintain detention?

A. It would appear so, yes.

Q. That, in and of itself, is a failure in the system of safeguards, isn't it?

A. Absolutely, yes.

Q. So we have dealt with the fact that you have identified that there was no suitable mechanism for the quality assurance and quality improvement activities that would be necessary for ensuring that the rule 35 processes were fit for purpose. I think you also identified that there wasn't any specific system in place for the re-evaluation of detained persons who have been identified as possible victims of torture in order to ascertain whether ongoing detention was indeed having a negative impact upon them. Is that right?

A. Yes, nothing that I could see indicated that people were taking that level of responsibility over somebody who has declared that they are a victim of torture, no.

Q. So there was no quality assurance of the rule 35 report itself, and then there was also no system for re-evaluating that person who had been assessed to be a victim of torture to assess the impact of their detention?

A. It was a "wait and see" approach.

Q. There is still no oversight mechanism in the Home Office for the quality of reports being done; is that your understanding?

A. It is my understanding, yes.

Q. That's clearly a concern, given how many do you have identified as being inadequate?

A. And the number of years over which this has clearly come to bear, so, yes, 100 per cent.

Q. There is also apparently no oversight of the reasons why so many rule 35 reports received by the Home Office don't lead to release of the detained person. Is that also a concern?

A. It is a concern. I don't really have a good understanding of that. I don't know what the pressures are from the Home Office's perspective. I would love to explore that in more detail and have an understanding of that because it might help in terms of -- in terms of that training, I think, as we go back to that, "Why are you doing this? Why do you need to do this? Why do you need to relay this information to the Home Office?", is it down to that that we have seen so few people released from detention on the basis of those reports? I don't have the answer to those questions and I don't know what the other pressures are in terms of them maintaining

detention.

Q. Dr Bingham gave some evidence that clearly the reasons for missing the safeguard are not that there is a lack of clarity in the form, at least, but that it's just not being done, first of all. And then that there's no -- as we have just established, there is no oversight and feedback mechanism and no quality assurance system in order to identify any of those factors.

A. Indeed.

Q. That really seems to be a systemic problem, doesn't it, as opposed to an individual one with individuals filling in the forms?

A. As well as the understanding aspect of it. You know, what are the human rights and the legal aspects of this and the rules and why they have been created in the first place, and I think, you know, that's a foundation that is clearly missing.

Q. If we can move on, then, to the other limbs of the rule, other than rule 35(3), you deal with those in both of your reports, but in your supplemental report at pages 29 to 30, you say, for example, that your understanding of the Detention Centre Rules is that, where there is an apparent deterioration of a detained person's health as a result of ongoing detention, there ought to be a rule 35(1) report; is that right?

A. Yes.
Q. In relation to rule 35(2), that's the limb that deals with a medical practitioner having a suspicion of suicidal intentions on the part of a detained person?
A. Yes.
Q. You say in your supplemental report that one of the aspects highlighted by the case studies is the apparent disconnect between the information known by healthcare staff and their ability to ensure a review by a medical practitioner was both timely and that it prompted the provision of a rule 35(1) or rule 35(2) report where appropriate, particularly where there'd been an apparent deterioration in the detained person's mental health or there had been an episode of self-harm or attempted suicide. Is that right?
A. Yes.
Q. So these things were being reported from your review of some of the records to various members of the healthcare staff, but they simply just weren't leading to reports under these two limbs?
A. No, they weren't.
Q. You go on to say there are several issues arising from these case studies. Firstly, it appears that there was no system in place for automatic review of a detained person where there was a self-harm, suicide attempt or

an apparent deterioration; is that right?
A. That's right.
Q. So, in those circumstances, which clearly, in your view, would meet the threshold of a rule 35(1) report, a rule 35(1) report simply wasn't being done?
A. No, and I think it appears that it was almost sort of left to chance as to whether or not the doctor may have seen them, because, of course, it's them who has to make the report. So there certainly doesn't seem to have been any specific system in place that called for that timely, prompt review for the need for writing one of those additional limbs.
Q. And the referral on to the GP, who, as you say, is the only person who can actually complete them?
A. Yes.
Q. You say, secondly, it appears that when the medical practitioner, the GP, was asked to review cases where there was self-harm, a suicide attempt or an apparent deterioration, there was no systematic approach to the use of rule 35(1) or rule 35(2) reports in order to notify the Home Office of these changes in presentation; is that right?
A. That's right.
Q. So even where the GPs were seeing them, in the presence of self-harm incidents or suicide attempts or apparent

deterioration particularly, for example, in their mental health, it simply wasn't in the GP's practice triggering those reports to be completed, when it should have done?
A. No.
Q. You say:
"Thirdly, there does not appear to have been any mechanism by which the detained person's circumstances were systematically reviewed by the GP in order to consider whether or not their condition had changed over time and whether the detention was having an impact."
Is that right?
A. Yes. I think the key here is that, if it was the case that you had identified somebody with particular vulnerabilities and you knew that either the Home Office was still in the position of making a decision or had made a decision that detention should continue, clearly, while that person is still in your care, you would want to have a system in place in order to detect that deterioration so that you could then follow that initial information transfer to the Home Office that this person is now -- you know, "There is an additional problem that you need to know about".
Q. Because they remain vulnerable?
A. Because they remain vulnerable and, in fact, they may deteriorate or may be deteriorating. The rate at which

they are deteriorating is clearly important to consider -- not essential, but it is important to consider -- so you would want to relay all of that information to the Home Office because, ultimately, you know, they are responsible for reviewing detention.
Q. It didn't -- there didn't appear to be any systemic provision for review over a period of time?
A. No.
Q. It appeared that when rule 35(3) reports were done, there was a practice of not completing any further rule 35 reports even if a detainee asked for one. Is that your understanding?
A. In terms of repeating a rule 35(3)?
Q. In terms of --
A. Or any --
Q. -- using the limbs under (1) and (2) because there had been a rule 35(3) report in place. There appears to have been a practice that, if there had been a rule 35(3) report, even where the thresholds for triggering the other two limbs occurred, the reports weren't being done?
A. No, they weren't, no.
Q. Of course, simply because one has a rule 35(3) report doesn't preclude having one at a later time under rules 35(1) and (2), does it?

A. No, it doesn't.
Q. Indeed, those reports should be being completed if the circumstances are appropriate, even if a rule 35(3) report has previously been sent to the Home Office?
A. Indeed.
Q. You conclude, effectively:
"In my opinion, the material provided indicates that there was a lack of clarity on the part of GPs as to the use of rule 35(1) and rule 35(2) reports during the relevant period."
And you say:
"In my view, this may have been in part as a result of the failure of the healthcare staff to trigger the review at the earliest opportunity."
So that's the referrals from other members of healthcare staff to GPs?
A. Yes.
Q. So it is failing at that level initially?
A. Yes.
Q. And then also have been partly because the GPs were not considering the provision of these reports when the opportunity arose during the relevant period, and so it failed at that second stage also at the GP level?
A. It did, and I think we heard that the custom and practice, as I say, almost unilaterally decided that

they weren't going to use those particular limbs or hadn't needed to because there were other mechanisms or that there was duplication in having written a rule 35(3) report that meant that writing a rule 35(1) or (2) was apparently unnecessary or appeared to be unnecessary.
Q. You say:
"As a result, it is my view that these issues contributed to an inadequate use of the system and would have led to delays or a failure in the notification of these issues to the Home Office."
A. Yes.
Q. The reasons the failures to complete rule 35(1) and (2) reports is so concerning is that, first, the Home Office is not notified of someone who is at risk of suicide or deteriorating in detention; do you agree?
A. Yes.
Q. But also, and perhaps more importantly, secondly, that the person remains in detention for the risk potentially to be realised; is that right?
A. Yes.
Q. In other words, the person remains in detention for harm actually to be caused to them?
A. It seems completely counterintuitive when you look at it. Without those safeguards being used to their full

force, if you like, at the earliest opportunity, then it appears that that is the only consequence, that people are likely to come to more harm.
Q. Rule 35(1), as we have established when we looked at the rule, doesn't require actual harm, does it?
A. No.
Q. It doesn't require harm to already have been caused. It is looking at a likelihood of harm?
A. Yes, and I -- again, I go back to the sort of conflict here. This is one of those other areas. I can see that predicting the likelihood of harm as being very difficult for a GP in this type of scenario. I think we're using to predicting risk around, you know, coronary heart disease and things like that because we have tools to assist us. But I also think the word "likely" is unhelpful here, because it does deflect you away from the issue, which is that you have a vulnerable person in front of you. Whether or not they're likely to be at harm is a secondary matter, in effect.
Q. They are likely to be at harm --
A. Full stop.
Q. -- by the very dint of the fact that they are vulnerable?
A. Yes.
Q. Which is what the risk indicators in the Adult at Risk

policy is designed to identify?
A. Yes.
Q. So if there are those identifiable risks posed to the person of harm by remaining in detention, the doctor should be notifying the Home Office, which is the body that has the opportunity, to review that detention and they need to do that immediately so that that harm is not realised?
A. Or minimised, yes.
Q. They shouldn't, certainly, be waiting to see if the person does come to harm in detention?
A. No.
Q. In practice, that clearly wasn't the way it was working. It seemed that it was only in quite extreme cases of harm already having been caused that were triggering a rule 35(1) report. Would you agree with that?
A. It appeared -- I think the rule 35(1) reports that I looked at appeared to be -- I'm not even sure they were connected, in a way. They appeared to be more detecting severe mental health problems. So it was more about the threshold of the use of the rule 35(1) rather than it necessarily being a consequence of the detention. It was whether I cannot manage this person in detention, therefore a rule 35(1). So I don't think there's -- there didn't appear to be a link in the

mind of the GPs that, "I will use a rule 35(1) because there is deterioration as a result of their vulnerability". It was because they met a particular threshold in relation to the severity of their mental health problem.

Q. Yes, so, "I, as a GP, can't manage them now in detention, so I'd best write a rule 35(1) report"?

A. Yes.

Q. That certainly doesn't fit with the Adults at Risk policy and the requirements of the rule to identify risk and not actual harm to the Home Office, does it?

A. Ask that question again, sorry.

Q. That practice doesn't fit with what the Adults at Risk policy is designed to do and the requirement of the rule to identify risk and not actual harm?

A. No.

Q. Instead, there was effectively a resort to managing those types of detainees on ACDTs; is that right?

A. Or not at all.

Q. Or not at all, yes, indeed.

A. Yes.

Q. Sandra Calver accepted in her evidence that the lack of rule 35(1) and (2) reports in the presence of a high number of open ACDTs, some involving, indeed, constant observation, which she said indicated a high risk of

suicide, indicated that too high a threshold was being applied and that there was a failure in the safeguards. You would agree with her, presumably?

A. Yes, I was quite shocked when I saw the number of ACDTs that had been opened and, obviously, when you take that in relation to the number of rule 35(1)s and the absence of rule 35(2), it's shocking.

Q. In your supplemental report, you said that, as indeed you'd outlined in your original report, the material provided to you indicated that there were only two rule 35(1) reports in the relevant period and no rule 35(2) reports in the relevant period, and you said you'd not been provided with a clear explanation as to the reasons why those particular reports were not utilised. In your view, the case studies indicated that the threshold for their use had been met, according to your understanding of the Detention Centre Rules. Does that remain your view?

A. That remains my view.

Q. You looked in particular at the case of D801, where a rule 35(1) report was provided but there appeared to be a delay in the completion of the report and the notifying of the Home Office, utilising that mechanism. We will come to his case in a bit more detail a little later, but that appeared to be an example where there

had been quite significant harm actually caused before a rule 35(1) report was done; would you agree?

A. Yes.

Q. You also said that, with particular reference to the case studies for D1914, D687 and D1527, the use of rule 35(1) and rule 35(2) does not appear to have been undertaken when there was an apparent deterioration in the detained person's condition. Again, we will come to them in some more detail later, but does that remain your view?

A. Yes.

Q. Dr Oozeerally gave some evidence about the reason for the lack of rule 35(1) reports, and in answer to the question:

"Question: What is the explanation for there only being eight rule 35(1) reports in 2017?"

He said:

"Answer: Because I think the management of that patient -- I would assume, because I haven't got all those documents, but actually, those patients were able to be managed within that detention environment and therefore it wasn't felt -- and that was the threshold that was in the rule 35 documents about, can you manage these patients in -- and if you're saying --"

I asked:

"Question: So you felt it was appropriate not to write rule 35(1) reports where their health could be managed in detention?

"Answer: I felt that that was certainly an aspect to it ..."

That's what you have just been describing, that the threshold seemed to be, are we incapable of satisfactorily managing them in detention, not, is there a likely deterioration?

A. Yes.

Q. That practice seems to have developed despite Shaw's recommendations to do away with the criteria of satisfactory management in detention and the fact that that phrasing doesn't form any part of the Adults at Risk policy to consider that; is that right?

A. Yes, absolutely.

Q. So people were -- decisions were being made to manage vulnerable detainees in detention instead of applying the safeguard under rule 35(1) as it should have been applied?

A. Yes, and I think, as I said earlier, this seems to have been a unilateral position that was reached over time and possibly for a number of reasons. Obviously, I haven't really been able to get to the bottom of why that has been the custom and practice in place, but it

certainly seems to contribute to an ongoing lack of an understanding of what those safeguarding mechanisms are trying to do and trying to achieve, and the priority that needs to be placed upon them in order to deliver effective safeguards.

MS SIMCOCK: Yes, thank you.

Chair, that might be an appropriate time to pause for a break. Can I say 11.40 am, please?

THE CHAIR: Thank you, Ms Simcock.

(11.26 am)

(A short break)

(11.46 am)

MS SIMCOCK: Doctor, I want to look at managing ill-health and particularly mental ill-health in detention. In terms of the profile of -- and detainees in an immigration removal centre, we have touched on this as well, a high proportion of detainees have clinically significant levels of depression, PTSD and anxiety; is that right?

A. That's my understanding. I mean, I have never seen anything in respect of the current population or during the relevant period that gives us a definition of the prevalence of those issues. I'm aware of the research that's been referenced that gives an indication of that, but nothing hard and fast that describes the

population as it is.

Q. PTSD is frequently linked with a history of torture or other forms of serious ill-treatment. Would you agree with that?

A. As I understand it, yes.

Q. Dr Bingham gave evidence that, for a victim of torture, experiencing a retriggering of symptoms of trauma is a source of extreme distress and suffering and that flashbacks are not just something that happen in passing, but it is really a re-experiencing of torture. For that person, it is as if they are being tortured again. Would you agree with that?

A. I'm not an expert. I'm not a psychiatrist, I'm not an expert in this area, but I can appreciate what she's saying, yes.

Q. Professor Katona, in his witness statement at paragraphs 95 to 97, said that someone who suffers from severe depression but is left in detention is likely to suffer from further loss of hope or motivation and may develop or worsen risks of suicide and self-harm. Would you agree with that?

A. Yes.

Q. People suffering from PTSD may go on to suffer secondary psychosis whilst in detention owing to the stresses of being there and re-traumatisation. Would you agree with

that?

A. I can see that, yes.

Q. We heard some evidence from mental health nurse Karen Churcher that Brook House was not an environment where it was possible, or appropriate, to give trauma-focused therapy. Were you aware of that?

A. Of the evidence, yes, that she gave, yes, I am aware of that, yes.

Q. So certainly trauma-focused therapy wasn't being provided in Brook House in 2017?

A. I didn't see any evidence of that, no.

Q. Sandra Calver gave evidence that it is not possible to provide CBT in detention, that detainees don't have access to a full range of psychiatric treatment in Brook House and that detention centres are not appropriate therapeutic environments to promote recovery from mental ill-health due to the nature of the environment and the lack of specialist mental health treatment resources. That also accords with the Royal College of Psychiatrists' position statement on the issue. Do you agree that an IRC is not such an environment?

A. Certainly not the way it's configured currently. It is not a therapeutic environment, no.

Q. Would you agree that segregation in particular can be

clinically harmful and may make things worse for someone with existing depression or severe anxiety, PTSD or suicidal ideation?

A. I can see that. I can also see, and in my experience working on the prison side, segregation sometimes for some people has, for them, in a way, a protective factor because it takes them away from an environment where they feel threatened. So it can give a bit of a closer eye on things. But there are two sides to every sort of evaluation of that. But I can certainly see, in relation to vulnerable detainees, it absolutely could be an exacerbation, or an increased exacerbation, of their underlying issues.

Q. Dr Bingham and Dr Paterson are of the view that segregation in particular is not an appropriate setting to accommodate vulnerable detainees with mental illness or at risk of self-harm. Would you agree with that?

A. Not as a general rule. I agree.

Q. If someone needs to be segregated, in other words, to go to the Care and Separation Unit, the CSU, or to be managed on E wing under rule 40, which deals with removal from association, then they must be very unwell, mustn't they?

A. I would hope so, yes.

Q. That should require a report under rule 35(1), at least?

A. Yes.
Q. Or potentially under rule 35(2)?
A. Yes.
Q. It requires a consideration of whether they are suitable for detention?
A. Yes.
Q. Do you agree that segregation should be a last resort?
A. Absolutely, yes. And -- yes.
Q. So the healthcare professionals involved all seem to agree that there's no real therapeutic intervention available, particularly for mental ill-health, in detention. Would you agree with that?
A. Yes.
Q. Everything appeared to be centred on risk management, didn't it? We can look at certain aspects of that. But if it is not -- the interventions aimed at dealing with mental ill-health, self-harm and suicidal ideation are not therapeutically based, they were effectively in order to risk manage those behaviours. Would you agree?
A. They certainly didn't seem to be very detained-person-centric in terms of their needs, no.
Q. There was a security focus?
A. Yes. Absolutely, yes.
Q. If we look at certain aspects of that, the ACDT tool is used as a risk management tool. It tends not to prevent

a deterioration in mental health and is certainly done with no GP input. Would you agree with that?
A. Yes.
Q. Again, that appears to be a custodial risk management tool and not any type of clinical intervention; is that right?
A. I agree.
Q. Evidence from the healthcare professionals to the inquiry confirmed that E wing was used to manage distressed behaviour, including self-harm and suicidal ideation, and certainly not for the primary purpose of providing treatment. Was that your understanding?
A. Yes, it seems to be done for the convenience of the staff and not for the benefit of the detained person.
Q. High numbers of people removed from association, informally and formally, under rules 40 and 42 to manage their self-harm or suffering from mental illness seemed to be occurring. Did you see evidence of that in the records you looked at?
A. Yes, and I think also the response for intoxicated people as well.
Q. Yes, indeed. So segregation wasn't being used as a last resort. It was being used as a risk management custodial type of intervention. Was that your

understanding of what was actually happening on the ground?
A. Yes. I don't see the logic of the risk management part of it because it feels like it was done almost as if there was nothing else to do, "So therefore we will do X", which is to remove from association. It didn't appear to have a finite or understood purpose to me.
Q. Certainly Sandra Calver accepted that it wasn't always being used as a last resort; it was actually, as you say, in order to do something?
A. Yes.
Q. Whilst on E wing and indeed the CSU, detainees were primarily being managed by detention staff with very little clinical input. Was that your understanding?
A. I didn't get a sense of any significant involvement of the clinical staff with the detained persons once they were in those aspects of Brook House, and that may be down to the fact that they weren't recording it in the clinical records or that it wasn't happening. Either way, I didn't see the evidence that it was happening.
Q. Clinical risk assessments weren't routinely done to screen for vulnerability when considering whether to use segregation. Sandra Calver accepted that. Was that your understanding?
A. Yes, indeed.

Q. Should they have been?
A. I think it goes back to the steps which are, am I detecting that somebody is vulnerable in this environment and, if I am going to then place them somewhere that could be even more harmful, there needs to be a step in place there to screen for that additional impact.
Q. Particularly where segregation may be positively harmful to someone who is particularly vulnerable?
A. Exactly. It is potentially additionally harmful dissociating for that individual, potentially. As I said before, there are occasions when, for some people, it may help to relieve their anxiety about being on a busy wing, for example, but, in the main, given the prevalence of the mental health issues that we see in this population, I would suggest that you need a robust additional step before the use of segregation in this group.
Q. And there didn't appear to be one?
A. No.
Q. Sandra Calver gave evidence that some people did indeed deteriorate mentally as a result of being on E wing. Was that your understanding as well?
A. Yes.
Q. So it seems that exactly what is of concern was

indeed -- there was evidence of it, indeed, happening?
A. Yes.
Q. Given all of that evidence, would you agree that the system wasn't just inadequate because rule 35(1) and (2) reports weren't being done, but also in several other quite serious respects?
A. Yes.
Q. So the safeguards have effectively been set up structurally to fail because, as we have established, a rule 34 compliant examination can't be done at the outset and the rule 35 process is therefore delayed. That's one aspect of a systemic failing?
A. They seemed largely absent. They are there occasionally, but not routinely and not consistently.
Q. When it was applied to a person, rule 35 wasn't being used effectively or indeed at all, as we have established, and ACDTs certainly didn't lead to rule 35 reports. Again, that's a systemic failing?
A. Correct.
Q. Nor, indeed, did food and fluid refusal lead to consideration of a rule 35 report: again, a systemic failing, not just up to individuals?
A. Yes, it appears that those sort of mechanisms went off down their own cul-de-sac and weren't connected back to those underlying safeguarding principles embodied within

rule 34 and rule 35, and there, in my view, needs to be a connection between all of those things.
Q. A disconnect, as you say. They seem to be operating in their own little silos?
A. Yes, absolutely.
Q. But not, as an overall consideration, systemically in relation to vulnerability and the need to review detention?
A. No.
Q. A practice, we heard, of using Part Cs to inform the Home Office of vulnerabilities or risks or incidents, indeed, had developed, and the difficulty with Part C being, clearly, that it doesn't require a review of detention by the Home Office; is that right?
A. That's my understanding. I know that we heard evidence that it did occasionally prompt -- apparently prompt a review of detention. Whether that is true or not, I don't know. But, nonetheless, it overlooks the founding principle that, if you have got the rules, then those are the things that should be used in order to prompt a review of detention.
Q. Indeed. And the importance of the safeguard is that it requires a response?
A. It requires a response.
Q. It doesn't leave it up to the person receiving it?

A. No.
Q. The consequence of all of that was that a number of vulnerable detainees were left in detention when they were likely to be harmed by that detention?
A. Yes.
Q. As we have just discussed, there were certainly no therapeutic ways to manage them if they became more unwell due to being in detention. ACDT wasn't a therapeutic intervention, there was limited psychological and psychiatric treatment available, no CBT, no trauma-based therapy. Again, a systemic problem?
A. Yes.
Q. The only options really centred around risk management and containment, as we have said: segregation, management on the ACDT as a custodial risk management tool. Is that right?
A. Yes, yes.
Q. And those options may actually cause someone to deteriorate further?
A. Yes.
Q. Even at that point, they weren't being identified for release under rule 35. That's a significant concern?
A. Yes.
Q. As we have heard, people who suffer from PTSD may be

reliving their trauma as if it was happening again whilst in detention. So positively being harmed?
A. Yes, absolutely.
Q. And people with depression may be deteriorating, also becoming more hopeless and increasing their self-harm and suicide risk?
A. Yes.
Q. Some, indeed, may have developed psychosis or psychotic symptoms or lost their mental capacity to make decisions about their care and treatment?
A. Indeed, yes.
Q. Is that right?
A. Yes.
Q. I think one example of that is D1275's case that you looked at briefly?
A. Yes.
Q. The entire system, in various respects, then, appears to be dysfunctional. Would you agree?
A. I would.
Q. Could we look at, then, some of the individual cases. I want to look first at D801. You considered his case at pages 40 to 48 of your supplemental report. He was someone whose detention began on 1 March 2017, and it was his second period of detention. After his first detention in 2015, which was also in Brook House, his

mental health had deteriorated in the community and he'd made two failed attempts at suicide. He'd been found disorientated and hanging on railings by the police on one occasion and brought to A&E. The Home Office, we know, were aware of those incidents, because they had received an independent medical expert's report saying that detaining him again would cause him harm and cause deterioration, but he was nevertheless detained in March 2017.

An ACDT was opened on his admission to Brook House on 1 March and, on 2 March, he was seen by Dr Belda, who was the psychiatrist at Brook House.

A. Yes.

Q. He recommended a hospital transfer. Just pausing there, you're not a psychiatrist, you're a GP, but would the fact that a psychiatrist had recommended he be transferred to an inpatient psychiatric facility indicate that he was really very unwell?

A. Yes.

Q. The hospital didn't accept his transfer on 8 March, but healthcare staff continued to be concerned about him and made entries in the records; for example, Sandra Calver on 13 March. In your report, you criticise the lack of a rule 35(1) report and a lack of a rule 35(2) report in these circumstances; is that right?

A. Yes.

Q. He was being managed entirely on E wing under an ACDT and, on 19 March 2017, he tied a ligature that appeared to be a suicide attempt. Again, at that stage, no rule 35(1) or rule 35(2) report was completed. In your view, should one or both of them have been completed?

A. Yes. I mean, I can't remember exactly what I've written in the paragraph, but I would have said, one way or the other, they should have been written in relation to that history.

Q. He was seen by Dr Belda on 31 March, who said explicitly that he was not fit to be detained at Brook House, as he couldn't receive appropriate treatment. So he was still of the view that he needed treatment that couldn't be provided in Brook House. During this time, D801 says to the inquiry that he was re-experiencing his torture from his home country and he told an independent expert that he couldn't eat, he was -- just stayed inside his room, he didn't want to socialise with anyone and the whole experience, to him, felt like walking on fire.

So, although he wasn't someone who was either physically assaulted by staff during this time nor verbally abused, leaving him in detention during this period for a total of 34 days caused him to suffer ill-treatment because none of the safeguards that were

meant to function to remove him from detention worked. Would you agree with that?

A. I would. It does bring up a couple of issues, one in relation to the psychiatrist apparently not being in a position to be able to do those rule 35 reports themselves, or, you know, in a clear understanding that they couldn't do them, making sure that the GPs did undertake that assessment further in order to notify the Home Office of that particular issue.

Q. Yes.

A. It strikes me that this is a really good example of a complete inattention of the understanding of the purpose of the rules and that there was an imperative to relay that information to the Home Office at the earliest opportunity with the mechanism that would have meant that a review of detention was undertaken at that point in time.

Q. Yes, at the earliest opportunity and then at every other opportunity?

A. And then at every other, yes, fair.

Q. And the fact that they didn't, caused him harm?

A. Yes. Yes, I can see that.

Q. We heard, and we have touched upon it, some evidence about a practice of completing Part C forms to the Home Office to indicate vulnerabilities or risk instead

of using rule 35 reports. That was a practice that appeared to have been at least approved by the Home Office, according to Sandra Calver. But the fundamental difference, as we have discussed, was that only rule 35 requires the Home Office to review detention; is that right?

A. That's my understanding.

Q. So if healthcare had been given an impression by the Home Office that they were either encouraging or at least content to receive Part Cs instead of rule 35s, that would be a misdirection by them, wouldn't it?

A. It would, and I didn't see any evidence that that was the case, which is to say that if a part C was received by the Home Office that contained information that otherwise should have been on a rule 35(1), (2) or (3), that they should, meaning healthcare should, complete the relevant form. I didn't see anything to that effect.

Q. Both Dr Oozeerally and Sandra Calver, as head of healthcare, gave evidence that they had never had concerns raised with them by the Home Office as to the lack of rule 35(1) or (2) reports. Would that be a concern?

A. It is a concern, yes. Yes.

Q. Dr Oozeerally gave evidence that the reason 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 is no statutory requirement of the Home Office to have done so.

When Dr Bingham gave evidence, she said that that wasn't Medical Justice's or her experience and that Part Cs didn't lead to a review of detention and, indeed, D801 was a good example of that because he had had four Part Cs completed in relation to his mental health and self-harm or suicide attempts during his period of detention in March 2017, and indeed his detention had been maintained. Were you aware of that?

A. Yes, and I don't know that I've seen anything in the evidence, orally or written, that accords with Dr Oozeerally's evidence that he gave that it was an effective mechanism.

Q. Dr Bingham gave evidence that there were also cases where there were concerns that not only was rule 35 not used, but no Part C was completed either. Was that also a concern?

A. Absolutely, yes, but we go back to rules 35(1), (2) and (3). Those limbs are there for a very good purpose and

I would rather they were used appropriately and accordingly rather than what appears to be a fairly one-sided decision, unilateral decision, just to use Part C instead.

Q. Rule 35 isn't optional?

A. No.

Q. If we look, then, more specifically at rule 35(2) reports, we know there were none in 2017, or indeed in the years thereafter. There were high numbers of ACDTs opened in that period, in the relevant period, in 2017. Suicidal detainees, we heard, were being managed on ACDTs using a constant watch; a constant watch indicating, as Sandra Calver accepted, a high risk of suicide?

A. Yes.

Q. You would agree with that?

A. Yes.

Q. There seems to have been a complete disconnect, as you have described, between the ACDT system and the rule 35 system, doesn't there?

A. Completely.

Q. Open ACDTs, even where there was a constant watch, simply weren't provoking the consideration of either rule 35(1) or rule 35(2), and you have mentioned that in your supplemental report. That's, again, a significant

concern?

A. It is, and I've had no explanation for that at all. I can't fathom why that might have come to be. It just doesn't make any sense to me.

Q. They could, and should, be linked?

A. Yes.

Q. You recommended better training in that regard; is that right?

A. Again, having part of that is the founding understanding of why you're doing what you're being asked to do: why do I need to fill in a rule 35(2) report? It's because I'm being given information that makes me suspicious that this person has a risk of self-harm or suicide and I need to relay this to the Home Office. It seems obvious to me, and when I look at the material it seems obvious, but, for some reason, it wasn't happening.

Q. It wasn't happening. It is particularly so in circumstances where, as we have established, the ACDT was, and is, a custodial risk management tool and not one designed to give any therapeutic intervention. So it is not an alternative, is it?

A. No, it is not.

Q. It is not a clinical tool and it doesn't address the underlying causes of self-harm or suicidal ideation?

A. No. Again, it would be, as put by Dr Bingham, you know,

it is essentially in order to keep somebody safe, but if you have the rule 35(2) alongside that whilst you're waiting for it, at least you can be reassured that you are keeping that person as safe as possible while asking for the review of detention.

Q. So it's not an adequate response on its own, is it, to an episode of self-harm or a suicide attempt in circumstances where rule 35 isn't being used?

A. No, and I guess this almost speaks back to that issue of desensitisation and normalisation, that, my population is likely to do self-harm at this sort of level and we will just manage it with an ACDT rather than considering our founding principles of what's embodied within the rule 35.

Q. So you recommend a more robust approach to the system of education and training for both custodial staff and healthcare staff on ACDT but also on rule 35?

A. Yes, I think there is an interesting point there, actually, which -- you know, I recognise that, as the healthcare providers, you are often sitting in your clinical work space, but, you know, your detained persons are living on their wing and will know many of the custodial officers, so they, therefore, are an important link to be able to identify any concerns that they may have and relay them to the healthcare. So,

yes, if they see deterioration, that should be an important part of that process. You are sharing -- you know, you are sharing that duty of care.

Q. Sandra Calver also accepted that the lack of rule 35(2) reports indicated too high a threshold was being applied to complete the form. You would agree with that?

A. 100 per cent.

Q. And that the safeguards were therefore failing. Dr Oozeerally gave evidence that he still never completes rule 35(2) reports. So it remains a significant concern, doesn't it?

A. Well, the threshold appears to be infinite and that doesn't make sense to me, because, as you say, even people with constant supervision at an immediate risk of threat to life or limb, are still not having a rule 35(2) report.

Q. Again, we heard some evidence that the Home Office hasn't, and still hasn't, raised any concerns with either Dr Oozeerally or Sandra Calver, both still in post as the lead GP in Brook House and the head of healthcare. That appears to be a tacit approval of their non-use, doesn't it, by the Home Office?

A. I wouldn't like to say on behalf of the Home Office whether they approve of it, but, as I indicated earlier, if they don't know about it, they can't deal with it.

But it should raise questions, absolutely.

Q. In circumstances where they know they are not being completed, the safeguard isn't being applied?

A. Well, they don't necessarily know that they should be completed, but I think the complete absence of them should raise questions about -- you know, as we all know, there is a prevailing level of mental health issues and a level of self-harm here. The use of other mechanisms that the Home Office would be aware of should have raised questions as to why there was a complete absence of rule 35(2).

Q. And continues to be?

A. And continues to be, yes.

Q. Can we look, then, at another case study, D1914. You discuss this case study at pages 23 to 30 of your supplemental report. You have also dealt with this case study in your original report. But just looking briefly at the details in relation to him, for example, on 5 July in 2017, D1914 was noted to have self-harmed by making cuts to his arms and neck and taken an overdose of his medication. We saw that -- the result of that act of self-harm on the Panorama footage, which you will be familiar with?

A. Yes.

Q. You say that, whilst an ACDT was opened, there was no

corresponding rule 35(2) report apparently provided to the Home Office to notify them of this change in his circumstances and, additionally, there was no rule 35(1) report, either, of his apparent deterioration on this occasion. In your view, there should have been both a rule 35(1) report and a rule 35(2) report, or at least one or the other?

A. Yes.

Q. On 13 July 2017, Dr Chaudhary completed a Part C relaying his concerns to the Home Office of the risk of his condition worsening in detention, but notably, again, there was no rule 35(1) report completed on that occasion, and there should have been?

A. Yes.

Q. Subsequently, there was a rule 35(1) report completed by Dr Oozeerally on 17 July and you say that in relation to that, clearly, although a rule 35(1) report was appropriate there, it should have happened earlier?

A. Much earlier, yes.

Q. In your original report, at paragraph 5.261, you dealt with some of the elements of -- in relation to this gentleman, his risk factors. He was someone who had a serious cardiac condition, having undergone a double coronary artery bypass graft, he had some cardiac symptoms whilst in Brook House and some abnormal blood

results and he was awaiting a further cardiac procedure. He also had some mental health issues and, as we have just talked about, some episodes of serious self-harm or suicide attempts whilst he was in Brook House. So here there were multiple indicators to flag up his risk in detention, weren't there?

A. Yes.

Q. As we have just dealt with, you commented on the failure in his case to do a rule 35(1), or indeed a rule 35(2), report. He is someone who should have been alerted to the Home Office very early on, shouldn't he, really, at the outset of detention, as someone not suitable to remain in detention; would you agree?

A. I would agree. The challenge here -- a little bit of that conflict that I spoke of earlier, about the GPs' sort of priority around the physical health perhaps, particularly in this case, which is, you know, can I manage a patient with these particular health issues -- and I'm talking about his cardiac histories, and there will be GPs across the country who manage these patients while they're in their homes, with having had coronary artery bypass grafting and being on this list of medications. It doesn't go in any way to speak of the particular vulnerabilities of this particular detained person, and I think that's the missing link

here, which is, I can manage the physical health and it is just a list of medications, so why couldn't I manage this person in a detained setting, without recognising the fact that that impact you have spoken of is an additional pressure within the environment that you need to take into account and doesn't appear to be taken into account, because the assumption is, I can manage this physical health problem.

Q. Yes. Particularly, he should have been notified under rule 35(1) because actual harm isn't required, only likelihood of harm is required, and he fulfilled those criteria at the outset, didn't he?

A. Again, as I say, I can see, from a GP's perspective, why you might think, "Well, actually, I can manage this, I almost can't see the likelihood of harm", but then, when you overlay that with his response to being controlled and contained in that environment and his response to that, then you can clearly see where there is a -- you know, a conflict there.

Q. That's -- so all the more reason to do a rule 35(1) report once he actually started to deteriorate?

A. Correct, yes. And that wasn't given any thought.

Q. He was getting, certainly, more agitated and frustrated by his detention, apparently, and his inability to access the treatment he required. That appears to have

been induced by his very detention, doesn't it?

A. It does. I mean, I recognise also that there were occasions where he was taken to hospital and he self-discharged or didn't wait, et cetera, and, you know, I can see that that's very difficult to know how to manage and what to do about that, because, on the one hand, you're trying to progress his physical health knowing that he's waiting for that further procedure to be done. How do you deal with that, you know, when that person comes back from the hospital having not had that assessment or that review done? Rather than taking the view that -- it is difficult to articulate, but it was, rather than taking the view that that's down to a deterioration, it's just taking a view that that's how he is.

Q. Yes, that he's deliberately --

A. And that it's deliberate or that it's intentional or there to frustrate the healthcare, and that's certainly how it comes across as being perceived by the healthcare staff.

Q. Dr Bingham gave some evidence about that, that he was an example of someone whose mental illness was essentially mischaracterised as refractory behaviour, and he was seen as non-compliant, not unwell. Would you agree with that?

A. That's how he was characterised, yes.

Q. He was subject, for example, to a planned use of force to facilitate his removal. Again, seemed to be being treated as deliberately non-compliant and not vulnerable and unwell?

A. As I alluded to earlier, it seemed to be done for the convenience of the custodial staff and not for his -- or consideration of his issues.

Q. On 19 April 2017, healthcare were asked to confirm whether D1914 was fit to be detained and fit to fly, in light of his emergency visit to hospital the previous day. In response, Dr Chaudhary stated that D1914 was fit to travel and to be detained. Seemingly, as a result of that letter, the Home Office filled in an airline risk assessment on the same day leaving the section blank that stated, "Are there any known health issues requiring mitigating action?" That's problematic, isn't it?

A. Yes.

Q. It is of particular concern?

A. Yes.

Q. No information was passed to the airline or to the officers tasked with the removal as to the fact that he had a serious heart condition and that stress may lead to a deterioration in that condition; he might even have

a cardiac arrest?

A. I think the confounding issue here is that stress and the sort of enforced removal and flight -- looking at the CAA guidance, you can see that, provided you meet certain criteria in relation to recent cardiac surgery, then, technically, you're fit to fly, and most GPs will be versed to looking at guidance like that in order to agree that they patient is fit to fly when they have had an operation not that long ago or they have a particular condition, and that guidance is pretty -- it is pretty straightforward. So you can see where the priority may have been placed on that component without necessarily, as I say, looking at the overlying stress that is going to then impact upon the individual, especially given the history that we know how he responds in stressful situations.

Q. Yes. The use of force upon him was approved by Dr Oozeerally in a letter to the Home Office on 27 May 2017, and he stated:

"The above detainee is fit to fly and fit for detention. He will need a medical escort due to the nature of his medical condition. I am happy for reasonable force to be used (C&R) in order to facilitate the removal."

Dr Bingham gave some evidence that healthcare staff,

which includes GPs, have an important safeguarding and monitoring role in relation to use of force. Would you agree?
A. Absolutely.
Q. The first, in relation to safeguarding, then, is to raise concerns or contraindications to a planned use of force, reasons why you might not want to use a use of force; is that right?
A. Correct, yes.
Q. The second clearly being to monitor any use of force that does occur and intervene if there were any concerns for the condition or welfare of the detained person. Do you agree with that?
A. Yes.
Q. In relation to the safeguarding role, then, it is important to raise concerns or contraindications when they are present and not to positively approve or sanction a use of force; is that right?
A. The doctor's role is definitely not to approve the use of force.
Q. Which is what Dr Oozeerally did here?
A. He did.
Q. That's completely inappropriate?
A. 100 per cent inappropriate. Unacceptable.
Q. Sandra Calver gave evidence that she wasn't aware that

the doctor was saying he was happy for reasonable force to be used and that she would have been concerned if she'd known, because it wasn't for them to decide on force being used. You'd agree with her?
A. Yes.
Q. No concerns or contraindications were, in fact, raised here by Dr Oozeerally, as we see. He did the opposite in his letter. That was despite the fact that this was a use of force not to save his life, so to safeguard his immediate safety, but was to remove him, to facilitate his removal, which Dr Oozeerally accepted was a situation in which it wouldn't be in the best interests of the patient to have force used. Would you agree with that?
A. Say that for me again?
Q. It wouldn't be in the best interests of a patient to have force used against them --
A. No.
Q. -- to facilitate their removal?
A. No.
Q. Really, the only time it is in the best interests of a patient to have force used against them is to immediately save their life?
A. Yes. Yes, I see what you're saying, yes.
Q. The letter Dr Oozeerally wrote also didn't contain any

information about D1914's physical medical condition or his mental vulnerabilities and self-harm. He said that was due to a non-medical person receiving it and also to patient confidentiality. But the effect is of concern, isn't it, because, in approving the use of force, those receiving that letter don't have any of the indications of why a use of force might be a risk?
A. So I think there are two issues here. One that we have heard about from I think it was Dr Bingham in relation to the sharing of information, and, I have to say, what I don't know is whether there is an information sharing protocol that exists in order for the sharing of medical information, but, nonetheless, the other issue is that it's quite possible to relay information about risks without necessarily revealing specific health information. Therefore, you're not necessarily breaching confidentiality. And of course, thirdly, as we have heard, you can always speak to the detained person and obtain their consent --
Q. Yes. Which wasn't done here, clearly?
A. -- which appears not to have been done. So, given what I've seen here in relation to this case, it would have been possible, I think, to relay a concern, a significant concern, about the use of restraints in effecting what they needed to, rather than positively

endorsing it.
Q. Dr Bingham was of the view that Dr Oozeerally should have raised both his physical medical condition and his mental vulnerabilities and self-harm as concerns or contraindications to the use of force in D1914's case. Do you agree with her?
A. I do, because I think this is going to be a complex problem for a number of people to consider: how are we going to address this? And you can see, with the underlying cardiac history and the additional stress of being forced onto a flight, that, you know, a disaster could happen.
Q. Yes.
A. And to not relay that in any way, shape or form is a failure, as far as I can see --
Q. Yes.
A. -- and, ultimately, could have led to a very, you know, serious incident or death.
Q. Dr Oozeerally said in evidence that he had considered his condition was stable. He later, on 17 July, in a rule 35 report, set out his history of two myocardial infarctions, two coronary arterial bypasses, that he was currently awaiting a cardiac catheter ablation for abnormal cardiac rhythm and that he had intermittently been complaining of chest -- there is a word missing,

I think, of "chest [something] during his stay", possibly "chest symptoms" or "chest pain" --
A. Chest pain, yes.
Q. -- and was recently sent to A&E, as healthcare felt he had reported. He said in that report:
"He is a high-risk patient in view of his medical condition and, although detention is not worsening his condition, the stress may trigger events that lead to another cardiac event."
Would you agree with all of that?
A. I would. I suppose, firstly, why was that not considered earlier? I guess one possible explanation might be that you needed to see that deterioration in order to form a view, but, nonetheless, I think it was considered far too late and it wasn't, certainly, considered at the outset. One might -- one knew his medical history at the outset. Therefore, knowing what immigration detention is ultimately for and what it may lead to, one needs to have those things in one's mind, ie, enforced removal, control and restraint, et cetera. So you would want to highlight those risks at the earliest opportunity, not at a late stage like this and certainly not in conflict with previous statements that one had already made a month prior.
Q. Dr Oozeerally would have known all of those factors when

he wrote that letter on 27 May. He should have been considering that those things were a concern and a contraindication to the use of force --
A. Yes.
Q. -- rather than saying he was happy for it to be used?
A. Yes.
Q. In that rule 35 report, in answer to the question, "What impact is detention or the conditions of detention having or likely to have on the detainee's health and why?", Dr Oozeerally referred to the history I have just given above, and then said:
"Ongoing stress and the unstable nature of his cardiac condition put his health at risk."
Is your view that his cardiac condition was unstable?
A. As I say, in terms of the physical health, from a GP's perspective, I can see how you could manage somebody in primary care just like this. If you add to it the additional stress of being in the immigration removal centre with the various things that may arise while you're in there, it is that that's not taken into account.
Q. Yes. This was someone who was still awaiting a further cardiac procedure --
A. Yes.

Q. -- and who had had cardiac symptoms. Those don't tend to suggest a stability of condition, do they?
A. Another way to put this is, if I had a patient like this in the community and I knew they were waiting for a procedure, I wouldn't necessarily be worried about them suddenly deteriorating, and if they did, they know what they can do: they can phone 999, they can ring the surgery, and we can assess them and we can give them advice. But there isn't, necessarily, an overlying current of additional stress which is there all the time. Clearly, if a patient like this came to me and said, "I'd like to run a marathon", we would have a different conversation.
Q. Or, "I'm going to be restrained"?
A. Exactly, or something intensely physical which may put their health at risk, which we know -- I think it is well understood that being restrained -- and stress certainly has a significant physiological impact on patients while they are going through that.
Q. So those are concerns that should have been raised at the time on 27 May in relation to a planned use of force?
A. Yes.
Q. And indeed, as contraindications to that use of force?
A. Yes.

Q. The decision, of course, on a use of force is a custodial one?
A. Mmm-hmm.
Q. As we have discussed. But in making that decision, it is important for those who are making the decision to have all of that clinical information and the view that it is a concern or contraindication to the use of force, isn't it?
A. In effect, it becomes their risk to manage, but they are looking to the medical professionals to give them some guidance as to what the problems might be; not necessarily how to manage it, but that there is a problem and that you need to think carefully about this. Once you have done that and provided that information, that you need to be careful in this particular case, then it becomes the custodial side's risk to know how to manage. That's why I say it becomes a complex matter, because you would potentially need observation, supervision, with a healthcare professional, while undertaking that, who has an understanding of what they are looking for in terms of that control and restraint.
Q. If we look at what happened, there is a transcript of the DCOs who were going to be carrying out the planned use of force talking about it in relation to D1914

beforehand. We can put it on the screen if it is helpful, <TRN0000087>, please, at page 20. If we look then a couple of lines down, Callum Tulley says:

"Just worried about this guy.

"Dave Webb: It doesn't matter.

"Callum Tulley: What if he dies?

"Dave Webb: No, we've got that disclaimer. So what we'll do is in the morning I'll grab that off of Knobby [Steve Loughton]. I'll take a couple of copies before all the paperwork gets tucked away. And I'll give you one.

"Callum Tulley: Cool.

"Dave Webb: So then in that way, if everything happens later on --

"...

"You've actually got a fucking copy of the doctor's letter."

This appears to be DCOs expressly relying on Dr Oozeerally's approval of a use of force, doesn't it? Would you agree?

A. I think the issue here, as I said earlier, it's the relaying of the risk, isn't it, to the parties that are going to be undertaking the use of force? And here, in a way, what they're saying is that Dr Oozeerally is taking that risk on his shoulders --

Q. Yes.

A. -- by saying he's approving for that use of force. But clearly, even, essentially, the lay people, the non-medical people, are aware that this is a concern, and that's wrong in a number of ways. They shouldn't be (a) defending their own actions or the consequences of those actions by simply having a disclaimer, because they have a duty of care also, but they certainly are, in a way, also misusing the information that's been provided to them in a way which is unacceptable.

Q. Yes. Again, a significant concern?

A. A significant concern, yes. Again, it doesn't really -- neither of them take any view of the detained person's perspective in this, which I think is also quite sad.

Q. A DCO later says in relation to D1914, and the planned use of force, "If he dies, he dies", a now rather famous quote from Rocky IV. Dave Webb also demonstrates incorrectly the use of a shield to Callum Tulley, who is going to be the one using the shield. This "disclaimer", as they put it, seems to have put Dr Oozeerally's patient in harm's way, doesn't it?

A. Yes, absolutely.

Q. Jon Collier, who's the inquiry's use of force expert, considered the use of force on 27 May 2017 and he concluded, at paragraph 124 of his report:

"My opinion and the reason for this incident being of high concern is that D1914 did not offer a level of threat to staff that justified their actions. If a full assessment had taken place prior to the intervention, I would not have expected to see them in full PPE. The force used was not necessary and more time should have been taken to try and persuade compliance with the instruction to move. I am even more concerned at the lack of consideration for the condition of D1914, who appeared unwell and unlikely to present a safety risk towards staff."

So that was his view. Does this incident show, effectively, a link between potentially life-threatening ill-treatment in the context of a seriously ill man and a systemic healthcare problem in the sanctioning of use of force by doctors?

A. Yes, I think that's probably fair. I mean, the only other thing that seems to be a factor in my mind, having read through the records, is whether there was a preconceived idea about the offending history, whether that played a part here and people were just naturally nervous about that and so felt that they had to escalate, and that is something that we frequently see, that the mechanisms are ratcheted up in order to sort of combat a particular situation rather than de-escalation.

So I take Dr Collier's -- Mr Collier's views, you know, that it seemed to be excessive. But I'm not, obviously, as you know, an expert in the area.

Q. So, stepping back and looking at the whole course of events in relation to this gentleman, there was a series of failures in the safeguards against detention of vulnerable people and treatment of his behavioural response to his mental illness as refractory behaviour, as we discussed, in the absence of treatment of him, which resulted in him being exposed to ill-treatment in the form of an unnecessary and excessive use of force against him?

A. Yes.

Q. Dr Oozeerally, as I have mentioned, completed a rule 35(1) report for D1914 on 17 July 2017 that stated he had no mental health issues, and this was despite the fact that D1914 had recently attempted suicide: so that wasn't accurate, was it?

A. No.

Q. He should have recorded mental health issues leading to a serious act of self-harm, shouldn't he?

A. Yes, at the very least.

Q. At the very least. Given that omission, that report is completely inadequate, isn't it?

A. Yes.

Q. And, indeed, done too late?
A. Indeed.
Q. If we look, then, next, please, at D687, you have dealt with him in your report -- both reports -- as well. page 26 of your supplemental report. D687 we know, on 15 April 2017, Dr Oozeerally completed a rule 35(3) report for him, but did not provide an opinion with regard to the impact of ongoing detention at that stage, and you say:
"In my view, Dr Oozeerally should have provided his opinion in regard to the impact of detention on D687 in this rule 35(3) report."
As directed by the form, indeed; is that right?
A. Yes.
Q. "Despite this, the Home Office's response concluded that D687 met the threshold for an Adult at Risk but that their decision was to maintain detention at that time."
So, again, the Home Office, having received a report, certainly didn't take a decision to release D687 potentially because the impact of detention hadn't been commented upon by Dr Oozeerally?
A. Yes. The absence of the information appeared to reassure them that things should just carry on as they were, detention should continue.
Q. On 5 May 2017, D687's condition was noted to have

deteriorated, and he was placed on an ACDT as a result of a reported intention to take an overdose. He -- an appointment was made for him on 10 May to see the GP but he didn't attend. There wasn't any rule 35(2) report provided at this stage, nor, indeed, a rule 35(1) report notifying the Home Office of an apparent worsening impact as a result of ongoing detention on him. You say, in your view, there should have been?
A. Yes.
Q. In relation to both rule 35(1) and rule 35(2)?
A. Yes.
Q. You also comment about the lack of follow-up in relation to him missing his appointment with the GP?
A. Yes.
Q. And you say:
"It is my view that the missed appointment on 10 May ought to have been followed up with a further appointment with the GP in order for them to assess the detained person and complete the relevant rule 35(1) and/or rule 35(2) reports."
Given that you say it is only a GP who can complete those reports?
A. Yes.
Q. You say:
"In the circumstances that the GP was either

unavailable at the time or the detained person remained unwilling to attend for an assessment, then in my view the GP should have completed the necessary reports based on the available records, notifying the Home Office of the change in circumstances."
Is that right?
A. Yes.
Q. Because there was enough information already to trigger the threshold?
A. Exactly.
Q. On 13 May 2017, there was a planned transfer to the Verne IRC and D687 protested by placing a ligature around his neck and that was subsequently removed during a use of force. Are you aware of that?
A. I am, yes.
Q. There was no entry in the medical records indicating that an ACDT was opened whilst D687 was still in Brook House. Should there have been?
A. Yes, even though he was leaving.
Q. It appears that following this particular incident, D687 was successfully transferred to the Verne IRC and, according to the additional medical records you have been provided with, he was subsequently provided on an ACDT there. You say he should have been placed on one at Brook House?

A. Absolutely.
Q. And also that the ligature incident should have prompted the provision of a rule 35(2) report at the time whilst he was still in Brook House?
A. Yes. Just because he was leaving shouldn't have prevented them from following their duties to notify the Home Office.
Q. Particularly as he was still going to remain in detention?
A. Absolutely, yes.
Q. You say:
"I note that following transfer to the Verne and the subsequent commencement of the ACDT, there doesn't appear to have been a rule 35(2) report provided there either."
A. No.
Q. It appears, by the time D687 was involved in the incident on 13 May, he had been presenting with deteriorating mental health symptoms for almost three months; is that right, from your review of the records?
A. I believe so, yes.
Q. He hadn't been prescribed any medication for that, such as antidepressants. During that time, he described multiple incidents in which he expressed suicidal ideation to staff, including the healthcare staff. You

note that it was clear by his rule 35 assessment on 15 April that his mental health was deteriorating, but that wasn't communicated to the Home Office by rule 35(1)?

A. It wasn't.

Q. And you similarly say that, by 10 May, it was clear that his mental health had deteriorated further since his rule 35 appointment with Dr Oozeerally on 15 April. Yet again, that wasn't reported by rule 35(1) or rule 35(2). Again, those indicate significant failures in the safeguards?

A. Indeed, yes.

Q. The Home Office, as we have just discussed, approved a request by G4S to transfer him from Brook House to the Verne, which did take place on 13 May. As a result of Dr Oozeerally's failure to report D687's mental health deterioration to the Home Office, that was something that they couldn't have factored into that decision whether or not to transfer him; is that right?

A. It is. The question that arises in my mind here is, what could be the reason, what was the reason, for the request for the transfer, and the pessimistic side of me feels that it was done, again, for convenience, that he was problematic in a way and therefore transferring him might be in their interests, not the detained person's

interests.

Q. The Home Office should have been aware of that deterioration --

A. Correct.

Q. -- in making the transfer decision, shouldn't they?

A. Exactly. Again, what it speaks to me of is this kind of, out of sight, out of mind approach, which, had they been following the processes for them in terms of advocating for their patient and notifying the Home Office, you are absolutely right, they would have then been able to factor that information into whether the transfer was in the detained person's best interests or not.

Q. A transfer shouldn't have been attempted before he had seen Dr Oozeerally following that missed appointment?

A. As I say, I don't know the full reasons for the request for the transfer, but certainly a decision about that I don't think could have been made without notification of that deterioration and the, you know, additional, very recent self-harm that happened at that time.

Q. In relation to his mental health, it was also untreated, wasn't it? He wasn't receiving antidepressant medication, nor, indeed, any other treatment. Should he have been prescribed antidepressant medication by Dr Oozeerally following his appointment on 15 April?

A. It is a difficult one to answer because, on one hand, I don't know whether, clinically, an antidepressant would have been the right treatment, whether it was, you know, even the -- what the detained person wanted in terms of treatment, whether it was offered or not, whether it was considered or not. I don't know. But arguably, I guess we are slightly deflecting away here from the real issue, which is that, actually, an antidepressant wouldn't necessarily have prevented deterioration. It is not a prophylactic treatment for the prevention of deterioration in immigration removal centre. That's not what it's for. So I wouldn't want that to distract us from the important issue that, if there is deterioration, simply prescribing an antidepressant --

Q. Isn't the answer?

A. Isn't the answer.

Q. Dr Oozeerally was asked about his consideration of antidepressant prescription on 15 April. I asked:

"Question: ... Did you consider prescribing antidepressants as a result of this consultation?

"Answer: The role of anti -- it doesn't ..."

I think it should say "look":

"... it doesn't look like I -- it does not say ... I didn't consider it."

Pausing there, another way of putting that is "It doesn't say I did consider it". It is an interesting phrasing by Dr Oozeerally?

A. Yes.

Q. "... It doesn't look like I decided at that point it was required. Antidepressants don't necessarily define someone's depression."

It wasn't documented as being considered. It appears it wasn't considered until 8 May when mental health nurse Karen Churcher raised the possibility and referred him for the further appointment with Dr Oozeerally on 10 May to discuss it further. We know he missed that appointment and he wasn't seen by Dr Oozeerally again before his transfer to the Verne. You also commented on that in your report and that steps should have been taken to follow him up with another appointment or submit a rule 35(1) report on the basis of the records?

A. Yes.

Q. The reason -- it was important for his non-attendance to have been followed up because the reason for the appointment was to do with a deterioration and a consideration of antidepressant medication, wasn't it?

A. Well, it was to do with the deterioration primarily, in my mind. As I said, I don't think the consideration of

medication in and of itself was the reason for the follow-up. I can't remember the detail. I would have to look at the clinical entry for the rule 35 report. But there certainly is enough information in there, had it been a normal GP appointment, if you like, to have considered somebody who was depressed and whether I should treat it. That would have been an adjunct if I was treating it in terms of his depression if that was the case at the time --

Q. Yes, I see.

A. -- rather than the only reason for considering the mechanisms that needed -- definitely needed pursuing.

Q. In your supplemental report at page 81, you say:

"I do have a concern that there does not appear to have been a consistent mechanism or approach to the follow-up and review of detained persons considered to be a victim of torture or an Adult at Risk where GP appointments have been missed, ensuring that possible deterioration as a result of ongoing detention is monitored and detected adequately."

That appears to be a systemic failing?

A. It does, and, you know, I can hear the people that are in the position of responsibility for resourcing this, you know, with their hair standing on end: "How on earth am I going to do this?" I can see there would be

a massive impact in terms of how you would organise your healthcare around that mechanism. But it seems, having reviewed all of this material, that that is essential.

Q. D687's description of the incident on 13 May with the ligature during his removal attempt is at paragraphs 194 to 214 of his witness statement. He describes there having given up on life, having lost hope and feeling worthless, and he explained how all of those feelings and others described in his statement contributed towards him attempting suicide on 13 May 2017. He says he wanted to die.

A. Mmm.

Q. Do you think that D687 not having been taking antidepressants is likely to have contributed to his experience of the incident on 13 May or not?

A. I think the challenge here is, if an antidepressant was considered, it would have been, in my view, I think, too early on in the treatment to have made a difference, a realistic difference, because you need to be on an antidepressant for a considerable period of time for it to reach its full effect, and that's variable from person to person. Equally, some people may not get on with an antidepressant, so you need to try a different one.

I think my understanding, in terms of the timeline,

is, it was too recent between the transfer when it could have started to have made any reasonable difference to his experiences on that day.

Q. You note that there is nothing in the system -- one entry for 15 April -- in respect of D687's rule 35 appointment to indicate whether or not Dr Oozeerally considered opening an ACDT at that time?

A. Yes.

Q. D687 has told the inquiry, in his witness statement at paragraph 158, that the rule 35 report doesn't properly reflect the interaction he had with Dr Oozeerally on 15 April. He disclosed certainly self-harm from two days earlier and showed the doctor fresh scars, and the doctor, he says, wasn't interested. He said -- he described the attitude of healthcare staff in his witness statement and he said:

"It felt like they didn't care and that they didn't believe you if you said you were unwell. They just wanted to move people along and nurses were just handing out paracetamol", effectively. I'm summarising.

In your view, if a vulnerable individual was to be met with attitudes such as those that D687 describes there, what impact would that have on their likelihood to make disclosures to healthcare of traumatic events in their life?

A. Well, they're less likely to, and we certainly know that some people won't necessarily disclose from the outset because of the, perhaps, shame or other emotions that they may have in relation to those incidents and the lack of confidence in the system, the authority, if you like, so it takes time for that to happen, and if you are then met with, you know, disbelief, disdain, you are -- you know, you're a nuisance or you're trying to subvert the system, that isn't necessarily doing to be received well, is it? I think you're unlikely to trust or you're less likely to trust.

Q. Would it also have an effect on the detained person's mental health, generally?

A. Yes, absolutely, yes.

Q. A negative effect?

A. Negative.

Q. Do you consider that Dr Oozeerally's failures in relation to rule 35 contributed to the incident on 13 May, because they led to an absence of a detention review, meaning he remained in detention, deteriorated and then was subject to a use of force?

A. Yes.

MS SIMCOCK: Chair, sightly early. That may be an appropriate moment to pause, just because I'm going on to another case study that is quite lengthy, and we may

then go for a period of time.
THE CHAIR: Thank you. That makes sense.
MS SIMCOCK: Can I say 1.55 pm, please?
THE CHAIR: Indeed. Thank you, Dr Hard.
(12.55 pm)
(The short adjournment)
(1.55 pm)
MS SIMCOCK: Doctor, I'd like to look now at the case of D1527 that I know you've looked at in some detail as a case study. When D1527 arrived in Brook House on 4 April 2017, he was already on an ACCT document from HMP Belmarsh; is that right?
A. Yes.
Q. Essentially, the document that the ACDT system is derived from?
A. Yes, as I understand it, yes.
Q. That prompted the commencement of the ACDT process within Brook House on that day. Although D1527 was seen by Dr Chaudhary on 5 April, he doesn't appear to have been provided with a rule 35(2) report on that occasion notifying the Home Office of his history of self-harm and suicidal ideation, and you say in your report that, given that D1527 was on an ACDT, in your view, he should have been provided with a rule 35(2) report on that occasion; is that right?

A. Yes.
Q. Or indeed, if not a rule 35(2), then a rule 35(1) report, because being on an ACDT with a history of self-harm and suicidal ideation indicated he was likely to be injuriously affected by detention; is that right?
A. That's my view, yes.
Q. Nine days later, on 13 April 2017, a rule 35(3) report was completed by Dr Oozeerally, and that referred to the fact that he was on an ACDT at the time of the assessment, but he didn't then do a report under either rule 35(1) or rule 35(2). Should he have done?
A. Yes, in my view, it should have been done.
Q. So simply because a rule 35(3) report had been done didn't obviate the need for a report under either of the other two limbs?
A. Not in my view and not to my understanding of the rules.
Q. Should even the rule 35(3) report have occurred earlier than nine days after he'd been received into detention?
A. I think, ultimately, yes, it should have done, because if the detained person had declared a history of torture at the rule 34 appointment, had that been in place, then arguably the rule 35(3) would have been done at that time, rather than potentially at a later stage or a delayed stage as a consequence of it apparently being picked up by another member of the team, and I can't

remember, without the records in front of me, at what stage that was picked up for that rule 35(3) appointment to have happened.
Q. Yes, but certainly not on his arrival or within 24 hours of --
A. It didn't happen, no.
Q. The rule 35(3) report, as I said, was done on 13 April. The response from the Home Office on 18 April concluded that detention would be maintained on the basis that the negative immigration factors outweighed the level of D1527's vulnerability.
The records then show that he remained on an ACDT document and was subsequently apparently refusing food. He then self-harmed by making cuts to his wrist on 24 April 2017. You say in your report these additional factors in D1527's case were not apparently relayed to the Home Office through the use of rule 35(1) or rule 35(2) in a report; is that right?
A. That's right.
Q. They should have been at that stage, shouldn't they?
A. Yes.
Q. Under either one or both of those limbs of the rule?
A. Yes, absolutely, yes.
Q. On the following day, 25 April 2017, D1527 was subjected to a use of force when he attempted to ligature and

swallow a battery and we know he was moved to E wing for closer observation. We will come to the incident on 25 April in more detail in a moment, but you say, thereafter, on 26 April, he was seen by Dr Oozeerally on E wing, and there is an entry in the records to that effect.
Despite the events of the previous day and the subsequent move to E wing, again, no rule 35(1) report was completed and no rule 35(2) report was completed. Either one or both of those should have been, shouldn't they --
A. Indeed, yes.
Q. -- at that stage? If not on the 25th, by a referral by the nurse involved in the incident immediately to a doctor on that day, then at least by Dr Oozeerally on 26 April?
A. Yes.
Q. The SystmOne records, the medical records, show that following this incident, he was -- continued to be observed on an ACDT document and continued to refuse food, but that, despite that ongoing deterioration in his presentation, again, there was still no rule 35(1) report provided to the Home Office. The continued refusal of food should have prompted further inquiry and consideration of a rule 35(1) report, in your view?

A. Yes.
Q. Again, all of those incidents and the case as a whole is another illustration of various systemic failures in the safeguards at each stage; is that right?
A. It is, yes.
Q. We have covered the general ways in which the case studies illustrate systemic failures. I just want to ask some further questions about your view on the particular case in relation to D1527 before coming to the incident. In your supplementary report at paragraph 3.3, you state that you stand by your opinion that the deficiencies you have identified in your original report -- and we have been through in some considerable detail this morning -- did not directly result in the mistreatment of detained persons, and I just wanted to ask you, having considered all of the evidence that you have now seen since completing your reports, including the live evidence you viewed to the inquiry, has your view on that issue changed at all?
A. Well, I suppose it depends what one means by "direct or indirect", and I think there are multiple layers to this. I mean, there's no evidence to say that a doctor or nurse went and directly did harm to an individual, but neither did they take care of the responsibility of the duty of care in an active way. So I would say that

that's an indirect means.
Q. Yes.
A. In other words, they didn't take responsibility for all of those steps and recognise the impact of the failings of taking those steps on what that might lead to. So that's my view on why it's an indirect, because they didn't directly cause the harm themselves. But there is no doubt the two things are linked.
Q. So it was through inaction rather than positive action, in other words?
A. Correct, yes, yes.
Q. Because, in respect of this particular detainee, D1527, it's clear from the footage that Mr Tulley recorded that staff didn't understand his mental health problems. They weren't concerned about his welfare, as such. They were rather frustrated by the presentation of his symptoms. Would you agree?
A. Absolutely.
Q. That's further demonstrated by the derogatory remarks that we hear from both detention and healthcare staff in relation to him, isn't it?
A. It is.
Q. So at least to that extent, you would agree that D1527, had his difficulties been identified and treated appropriately, he might have avoided that ill-treatment?

A. He might have done, but I think, generally, from my view of all of the material that's been provided, I think there's also the cultural aspect of it, in terms of how you approach this sort of complexity, and I think that was also lacking.
Q. Yes, another failure.
A. Yes.
Q. That indicates a link, at least, between a systemic failure to diagnose, manage and treat mental health difficulties and ill-treatment by staff, doesn't it?
A. Yes.
Q. Including, clearly, the failure to complete rule 35(2) or indeed (1) reports, despite his suicidal ideation and episodes of self-harm?
A. Yes.
Q. Which led to force being used upon him --
A. Yes.
Q. -- by Yan Paschali and his colleagues in the manner we see on the footage?
A. Indeed. I think the issue here is that, again, it feels a little bit like the discussion we had earlier around rule 40 and removal to segregation. It almost feels like that was the thing to do at the time because there were no other options.
Q. So the thing to do was to use force?

A. Use force.
Q. And it clearly went far too far in this particular incident?
A. Absolutely, yes.
Q. I just want to deal, then, with the healthcare aspect to the particular incident with Yan Paschali as it relates to, as she then was, Nurse Jo Buss. There are several aspects to it. So the first is in relation to inappropriate comments. When detention staff that we see on the footage made comments about him and sometimes in his presence that he was a "cock", a "tool", a "Duracell bunny", an idiot, a baby, those types of remarks that we have all seen and heard, Ms Buss should have challenged them directly, shouldn't she, at the time?
A. Yes.
Q. She should have reported them as well, shouldn't she?
A. Yes.
Q. To her line management or theirs or both?
A. I suppose it depends what the line management would have done about it, but arguably just to leave it go unchecked, again, is a failure in its own right.
Q. She clearly --
A. And to be complicit with it.
Q. Absolutely. And, clearly, as she's accepted, she

shouldn't have made the comment "he's an arse" either? We all agree that's inappropriate?
A. Yes.
Q. And derogatory?
A. And derogatory, yes.
Q. So moving on to the incident itself, then, in relation to the use of force, and, in particular, what we have all seen Yan Paschali's role was in that, it's quite clear that if Jo Buss had seen what Yan Paschali did with his hands around D1527's neck, the so-called choke hold, she should immediately have told him to stop, shouldn't she?
A. Absolutely, yes.
Q. Likewise, if she heard him saying he was "going to put him to fucking sleep", she should immediately have challenged Mr Paschali again?
A. Yes.
Q. Because that's a direct threat, isn't it?
A. Yes.
Q. And would have been perceived as such by D1527 at the time, you would agree?
A. Absolutely, yes, yes.
Q. She had a duty to intervene, in the circumstances?
A. Yes, she did.
Q. At the time, immediately?

A. Yes.
Q. If she had had Callum say, "Yan, easy, easy", as, again, we have heard on the footage, that should have caused her a concern and, again, she should have intervened or enquired further as to what was happening, shouldn't she --
A. Yes.
Q. -- to ensure D1525's welfare?
A. Yes. No doubt you may be coming on to this, but from what appears to be from where she was standing and her inability to see what was going on, arguably, intervening should have been at the forefront of her mind pre-emptively in regard to some of the things that you have just set out, or at least to have been able to have seen what was going on.
Q. We will come to that, as you say, in a little more detail in a moment. If she had heard D1527 say, "My neck", which he is heard to say five times on the footage, on any one of those occasions, and indeed on all of them, had she heard them, she should, again, have raised a concern as to what was happening with his neck, given he was under restraint at the time?
A. Yes.
Q. She should at least have enquired what was happening, both of staff and of him, shouldn't she?

A. I would say more than enquired, because, given the complexity of what was physically happening in that situation, it was her duty to get amongst it and see what was going on and to take the relevant actions and the relevant steps at the relevant points, rather than to be a passenger in the situation.
Q. Ms Buss gave evidence that she hadn't seen or heard those things I have just described, contrary to her admissions in her NMC disciplinary proceedings, because if she had, she said she would have intervened. Whether she did or not is clearly a matter for the chair to consider in due course, but I want to ask you, as you have anticipated, some questions based upon her current account, that she couldn't, and didn't, see those things and she couldn't, and didn't, hear those things.
We have already considered the important monitoring role that healthcare staff who attend a use of force hold. That's an important safeguarding role, isn't it?
A. Yes, it is.
Q. She accepted, in her evidence, that she was carrying out and had a duty to carry out that role to safeguard D1527's safety and welfare, and you're in full agreement with that?
A. I'm in agreement that she had a duty to do that. I'm not in agreement with her actually doing it.

Q. Yes, absolutely. She said she was monitoring him visually. She had an obligation, didn't she, to put herself into a position to be able to see and hear what was going on in this restraint?
A. Yes, she did.
Q. She accepted that it was particularly important to be able to see his face and neck in order to monitor his breathing, to check that there was no obstruction to his airway, and to monitor his level of distress. Do you agree with that?
A. Yes, I do.
Q. As we now know, it was also important to be able to see that he was being choked?
A. Indeed.
Q. But if, as she now says, she couldn't see his face and neck and that monitoring -- then that monitoring wasn't being carried out adequately, was it?
A. No, it was not.
Q. Or indeed at all?
A. Indeed.
Q. She had a duty, if she couldn't see and hear, to do one of several different things, didn't she: she could have, for example, put herself physically in a position to be able to see and hear, couldn't she?
A. At least to try or to make it clear that she was wanting

to do that or to try to do that to let the officers know that was her intention, "I can't see. I need to see what's going on".

Q. Indeed. If that wasn't possible, for some reason, as she seemed to suggest, to some extent, in her evidence, then her duty was to raise a concern with the detention staff that she couldn't see and couldn't hear?

A. Yes.

Q. So she couldn't monitor his welfare in the restraint. That's right, isn't it?

A. Yes, indeed it is.

Q. She didn't do that?

A. No.

Q. A third option would be simply to stop the restraint, wouldn't it?

A. Indeed, yes.

Q. To say, "Hands off. I can't see and I can't hear"?

A. Yes.

Q. She didn't do any of those things. Had she been adequately safeguarding his welfare in those circumstances?

A. Say that again, sorry.

Q. She didn't do any of those things?

A. She did not do any of those things.

Q. Was she adequately safeguarding his welfare in those

circumstances?

A. No.

Q. Her actions, or at least her inactions, exposed him to further mistreatment, didn't they?

A. Yes, they did.

Q. I just want to very briefly look at three short pieces of footage. Could we have KENCOV1007 V2017042500021, please, at 07:05 to 08:25, please.

(Video played)

MS SIMCOCK: I wonder if we could just take a couple of minutes? There seems to be a problem with the sound. If we could just enquire and try to fix it.

THE CHAIR: Would you like me to rise for a few minutes?

MS SIMCOCK: That would be great.

(2.17 pm)

(A short break)

(2.21 pm)

MS SIMCOCK: We seem to have fixed it. 07:05 to 08:25, please.

(Video played)

MS SIMCOCK: Nurse Jo Buss would have heard the sound that D1527 was making here during this choke hold, as it's been described, incident. Whether we call the noise he's making "choking" or some other description, should that noise that he's making that we hear in that footage

just there, particularly towards the end, have prompted a concern on her part, in your view?

A. If, indeed, she was standing within hearing shot of that, and I'm not sure precisely in my mind where she is at this point.

Q. If she heard that, she should have raised a concern at that stage?

A. Yes. Yes, yes.

Q. She accepted that she could see four people restraining him on the floor in the general sense of she sees that there are four people there and the restraint is happening on the floor. She described them as physically struggling. She didn't intervene during any of that process. Was there a point she should have intervened, or at least raised a concern, even had she not seen or heard that precise --

A. I think, as you say, the noises of the apparent inability to breathe would have -- should have stimulated some action. Certainly what appears to be very audible words from Yan Paschali's mouth about intending to put him to "fucking sleep" should have absolutely raised a concern.

Q. If we can just play on from there to 10 minutes, then, please. Thank you.

(Video played)

MS SIMCOCK: At the beginning of that clip, at around 08:38 to 08:42 seconds, Nurse Jo Buss accepts that the person whose feet you can see on the right-hand side of the screen to Yan Paschali's left was her.

A. Yes.

Q. So she was certainly present right beside D1527 and Yan Paschali at that stage of the clip and would have remained in the vicinity thereafter. Are the noises that he's heard to be making at the beginning of that clip of concern?

A. Yes, they are, yes.

Q. She should have intervened at that stage?

A. Absolutely.

Q. Towards the end of the clip there, from somewhere around 09:30 to 10:00, the last 30 seconds of the clip, D1527 is forcibly put into the recovery position by the detention staff, and we can hear on the footage the noises he's making at that stage. Ms Buss accepted that he was in very severe distress at this point and that it was obvious he was mentally unwell. Would you agree?

A. Certainly highly agitated, did not have a normal respiratory rate and wasn't, you know, making those noises for no other reason. Yes.

Q. She should have intervened, certainly at that stage, and raised a concern, shouldn't she?

A. I think at the latter point, it was probably too late, but, certainly, to attend to essentially her patient in some way in a supportive manner would have been what I would have expected.
Q. Yes. If we play then, please -- can we move on to 12 minutes, please, and play just for 30 seconds or so.
(Video played)
MS SIMCOCK: We can see Nurse Jo Buss in the picture, can't we, and we can see that Charlie Francis, the person physically on D1527, is still applying restraint on the floor, isn't he?
A. Yes.
Q. That's what we can see in the footage. Nurse Jo Buss accepted that she could see and hear D1527 at this point, as, of course, is obvious from the footage. Should she have been concerned -- raised a concern and intervened at this stage?
A. As I say, it's hard to understand what Charlie Francis is actually doing in terms of restraint at that point, but to show some level of concern for the welfare of the detained person who is lying on the floor in a very distressed state might have been the appropriate thing to do in this situation. But I don't see anything other than what appears to be disdain.
Q. Yes, her being a bit fed up, head in hands?

A. Yes, I can't rationalise that approach to my mind. Intervening, in terms of some other action, ie, to push Charlie Francis off or tell him to stop, I'm not sure, from what she can see, how she would intervene other than to say, "Look, can we give him some breathing space".
Q. To stop the restraint, "I think we should stop now"?
A. Yes.
Q. After the incident, there was a conversation between Callum Tulley and Jo Buss concerning the use of force form, the documentation, in which she accepted that she understood from Callum Tulley that the use of force form, the documentation, that the detention staff were required to fill in wasn't going to be recorded, and it wasn't going to be recorded, therefore, as a restraint at that time. She should have challenged that, shouldn't she --
A. Absolutely.
Q. -- with them immediately at the time, "You need to fill in the form"?
A. Yes.
Q. And, indeed, she should have reported it to her line management, their line management or both?
A. Yes. Yes, it should have been recorded. That's non-negotiable.

Q. And not just that -- the healthcare section of the documentation that she's responsible for, but in understanding, as she did, that the detention staff weren't going to fill in their side of documentation, she should have challenged them in that and reported that up to line management?
A. Yes, yes.
Q. If we look, then, at the documentation, the ACDT document has an entry from Jo Buss in it. If we look at, please, <CPS000009>, at page 8, please. The second entry down, Doctor, do you see says -- it is 25 April. There is one at 19:01 and then there is one at 19:40. Do you see that?
A. Yes.
Q. It says:
"Seen in room 7" -- this is the one at 19:40:
"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. Resp 16."
So respiratory rate of 16. Is that right?
A. Yes.
Q. That's the extent of the documentation by Jo Buss in that document. In your view, does that entry accurately

convey the nature of D1527's presentation and the restraint on him, even on the basis that she hadn't seen the choke hold?
A. Not remotely.
Q. It's not adequate, is it?
A. Not adequate at all.
Q. He was certainly more than angry and upset; would you agree?
A. Yes. I mean, it's deficient in a number of areas. It doesn't go in any detail to the length of the incident, you know, what --
Q. The severity of it?
A. The severity of it. Respiratory rate of 16. It was clearly not a respiratory rate of 16. We can hear it at the end. And, in fact, even at that point, before he's rolled into the recovery position, his respiratory rate is -- I mean, it's certainly well above 16. 16 is a normal resting respiratory rate. He was not normal and resting and breathing at a normal respiratory rate at that point when he was being restrained on the floor.
Q. Even if he ended up later under her observation at a respiratory rate of 16, this entry in no way records in several respects the true nature of what we see on the footage, does it?
A. And it fails to mention that use of force was required.

Q. If we look, then, at the medical records entry, can we see, please, <CJS001002> at page 38. If we go down, please, to 18:51, this is the entry that Jo Buss made after the incident in the clinical record. We see there it says:

"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 is no mention in that entry of a restraint or a use of force at all, is there?

A. No.

Q. There should have been, shouldn't there?

A. Yes.

Q. "Had placed a ligature around his neck. Removed by staff" clearly doesn't adequately record the use of force upon D1527, even leaving aside if she had seen the choke hold or not?

A. Indeed it doesn't.

Q. It doesn't accurately convey the totality of the nature of the incident, does it?

A. Not even remotely.

Q. Nor the nature of his underlying clinical presentation, his severe distress, the fact he seems to be mentally unwell?

A. It doesn't.

Q. "Angry and not engaging with staff" doesn't begin to describe his mental health presentation?

A. No, and it feels somewhat blaming of the detained person for the incident.

Q. Yes. It certainly doesn't describe his level of distress?

A. No.

Q. We know he is a person who had post-traumatic stress disorder. Would he likely have been very frightened by this incident?

A. Who wouldn't be?

Q. It would have been perceived as an extremely threatening situation by him?

A. I can't imagine it. I've not been through something like that, but the mind boggles.

Q. This type of terminology, as you say, rather blaming of the detained person themselves --

A. Mmm.

Q. -- that really misses the more clinical observations that you would expect clinically trained staff, such as a senior nurse, to have been able to make in this record about the levels of his anxiety, his distress, his mental health symptoms, doesn't it?

A. Yes.

Q. If we can look at the last piece of documentation in relation to this at <CJS005534> at page 10, please. This is the use of force form. This page is the page in relation to the incident in relation to a report of injury to detainee. This section is blank because this is the section that should have been filled in by detention staff. If we go over the page to page 11, please, this is the entry that was made by Nurse Mariola Makucka, Nurse Buss said on her instruction and on her behalf. We see there the time and date of the examination as recorded as 25 April 2017 at 19:00 and the report is:

"Seen on E wing. Room 7. By RGN Jo. 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. Slight redness noted on his neck."

And the body map is filled in with "slight redness on his neck". Do you see that?

A. Yes.

Q. Given this is recorded in a use of force form, we can at least understand that some force was used upon D1527 during this incident, can't we?

A. And that an injury had been sustained.

Q. Yes, the redness to his neck, indeed.

A. Yes.

Q. But, again, does this brief note in any way convey the seriousness of the incident we see on the footage?

A. No, it doesn't, and the additional concern is that it's not completed by the person who was there, so how could it possibly be completed accurately, unless it was dictated, in which case, why didn't she write it herself?

Q. So in considering the totality of the documentation, those three entries we have just been through, that doesn't meet the standards required of a nurse in terms of filling in documentation, does it?

A. No. No, it doesn't.

Q. Had we not got the footage, we would not be able to

have, and neither would anyone coming after this incident, reviewing these documents, any appreciation at all of the true nature and seriousness of this incident, would we?
A. I agree.
Q. Completely unacceptable?
A. Completely unacceptable.
Q. And a failure in her safeguarding role?
A. It opens the question as to how many other times this has happened unchecked.
Q. Absolutely. D1527's case is an example of a resort quickly to a use of force as a response to an incident of self-harm that seemed to be quite widespread in Brook House; would you agree?
A. It appears to be, yes. As I say, it seems to be the sort of go-to option.
Q. Certainly not used as a last resort?
A. No.
Q. And certainly not used only in the immediate life-saving sense?
A. I think in this case there clearly appeared to be a ligature around the neck, so I can understand the need to intervene for life saving.
Q. But once the ligature is removed?
A. But once the ligature is removed, and that appeared to

happen relatively quickly, the incident, therefore, should stand down or be withdrawn so there is no longer any further restraint or, you know, just involvement with the detained person given the space to breathe and to come to terms with what's been happening, rather than persisting with it.
Q. There is no --
A. Which seems to have been intentional, in terms of some form of reciprocation, some form of punishment.
Q. There was no corresponding consideration of rule 35, as we have established?
A. No.
Q. Or to any other clinical interventions at all, from the records?
A. Not that I can see.
Q. That remains of considerable concern even today, doesn't it, if that's continuing, to resort quickly to use of force, and in the absence of rule 35 reports and in the absence of clinical or other interventions?
A. And, additionally, left unanchored in the medical records. "Please review later" doesn't, equally, go as far as I would expect it to in terms of a clinical handover both in terms of what's documented there but also in terms of what would need to happen outside of that in order to ensure that staff, healthcare staff,

were following up -- following on from an incident like that.
Q. We know that the most recent IMB report recorded that 37 per cent of use of force incidents were as a response to self-harm. That is of considerable concern in and of itself, if those are the types of numbers we are seeing in terms of use of force as a response to self-harm; would you agree?
A. Yes.
Q. Again, in relation to use of force, you make a recommendation that there clearly needs to be a more robust approach to the system of education and training for both custodial and healthcare staff, and ideally, you say, in relation to use of force, training provided should involve the opportunity to train both custodial and healthcare staff alongside one another.
A. Yes.
Q. And you say this will help to ensure a co-operative and collaborative approach is developed between the two elements who owe a duty of care to the detained persons within Brook House and a better understanding of each other's roles and responsibilities. In your view, was there clearly a lack of understanding of the roles and responsibilities of the other type of staff?
A. Yes, I think so. Yes. I mean, it appeared that the

custodial staff, or one particular member, was acting essentially with impunity, "I can conduct myself how I please, knowing that I'm not going to be challenged".
Q. And clearly --
A. By the countering, by the healthcare side, let alone by the other custodial officers.
Q. Better training and a more robust approach would ensure healthcare staff have a better understanding of their own role in regard to the recognition of any poor practices or ill-treatment by detention staff. Is that your view as well?
A. It is. But I think the point I'd also like to make is, we should be looking at means to reduce the use of force as much as possible, and it is a last resort. So I wouldn't want use of force to become as resorted to as regularly as it appears to have been and that that training is there to support that ongoing use of force, if you see what I mean. It is more to make sure that when it does happen, and hopefully less frequently, that it is conducted correctly.
Q. And that the healthcare staff truly understand --
A. Truly understand, yes.
Q. -- their safeguarding and monitoring role?
A. Yes.
Q. And actually carry it out?

A. Yes.
Q. I'd like to move on then to D643. D643 was a combat veteran who served in the British Army in Iraq and Afghanistan and had been diagnosed with PTSD prior to entering immigration detention and an entry in his prison records confirmed that: he was detained on four separate occasions -- in June and July 2016 for 24 days; in August 2016, for seven days; in October and November 2016, for 23 days; and then, finally, between 21 December 2016 and 8 May 2018, for 504 days. By the time of his fourth time in Brook House, that last occasion when he arrived on 21 December 2016, he had been through three separate health induction assessments and screening process, but the medical assessment on his last occasion didn't mention a history of PTSD or of previous suicidal ideation.
Does that indicate both a systemic failure in the screening and the application of the rule 34 and 35 process?
A. Yes, it does.
Q. Is it indicative of a lack of a system to identify and cross-refer to previous medical history?
A. At least, yes.
Q. That's potentially harmful in individual cases?
A. Yes.

Q. D643 spoke fluent English. He'd served in the British military and he had experience of obtaining PTSD treatment both in prison and in the community?
A. Yes.
Q. He says that he asked on several occasions for help whilst in Brook House. The extent of the help he was offered was attendance at an Emotional Health group, which inevitably couldn't focus on his PTSD and, he said, he didn't find helpful. He says he was promised a referral to a psychiatrist, but that never happened. This is another example of an underlying condition, PTSD, not being identified in Brook House, and so it couldn't be, and wasn't, treated; is that right?
A. It certainly wasn't considered in that way, no.
Q. It ought to have been identified and clear from the outset, oughtn't it, given it was in his medical records?
A. Yes.
Q. If someone in D643's position couldn't get the help he required, despite speaking English fluently, and being able to identify precisely what he required -- treatment for PTSD -- does that indicate that it would have been even more difficult for others not in that position to do so?
A. Yes, absolutely. Yes.

Q. It might be practically impossible, with limited English, with limited knowledge, or with limited insight into your own condition due to an experience of trauma to access anything, mightn't it?
A. Yes, need of interpreters, all of these things, have a potential resource implication which don't appear to have been used systematically in order to go to the full depth that was required.
Q. In your supplementary report at page 64, you mention the lack of time limits in immigration detention, and the effect that that might have on detainees. On the fourth occasion D643 was detained at Brook House for a total of 504 days, notwithstanding his diagnosis of PTSD and the lack of treatment offered to him, is it inevitable that a detention of that length in an environment like Brook House of a person with those vulnerabilities would lead to harm coming to him?
A. I can't see any other way, and I think even somebody without those underlying issues would find it difficult and would deteriorate in an environment like that.
Q. In his case, does it indicate a complete failure of the systems designed to protect vulnerable detainees?
A. Yes.
Q. A case progression panel on 21 November 2017 reviewed his case but recommended continued detention without any

mention of his mental health. Does that indicate a lack of coordination between detention reviewing staff and healthcare?
A. Yes.
Q. D643 says that he either informed healthcare that he was feeling suicidal or was identified as having suicidal ideation on at least four separate occasions whilst he was in Brook House. On at least four other occasions, he says it should have been clear to the healthcare team that he was presenting with symptoms consistent with suicidal ideation or intentions. He certainly described having flashbacks and crying, isolating himself away from others. He said he felt depressed, anxious and was struggling mentally. Should all of that have prompted a rule 35(1) report to be produced?
A. Even in the absence of a specific diagnosis of PTSD being made, yes, I think it should.
Q. Should it also have prompted a rule 35(2) report, if he was expressing suicidal thoughts or ideation?
A. Yes.
Q. You say in your supplementary report, again, that the mechanism for the generation of a rule 35(2) report in response to suicidal ideation does not appear to have been working effectively in Brook House. But his experience, together with that of D801, D687, D1527 and

D1914, appears, at least, as consistent with a complete systemic failure, doesn't it?

A. Yes, it does. It wasn't happening at all.

Q. And, of course, we know, in the light of no rule 35(2) reports ever being completed in 2017, that indicates a complete systemic failure?

A. Yes.

Q. In the context of a self-evidently life-threatening scenario: a suicidal risk?

A. Yes.

Q. In terms of healthcare management from day to day, does that also -- do those case studies and the evidence we have about them also suggest inadequate management of staff, given their failure to fulfil their obligations under the rules and a resort to potentially harmful practices such as the use of segregation and sanctioning the use of force?

A. There certainly didn't appear to be an appropriate mechanism for ensuring that those balance -- checks and balances were being used in the correct manner. I don't know whether that was down to a lack of inattention generally or whether it was an additional frustration with the system, but it wasn't happening and should have been happening. So you would expect that the members of the clinical team working underneath the head of

healthcare would have, you know, felt it important to be checked, in terms of the management of their head of healthcare that these things were happening and, where there was any doubt, they should rightly ask the head of healthcare what should be happening.

Q. So had there been adequate day-to-day management of healthcare staff, you would have expected those safeguards to have been operating effectively?

A. Yes.

Q. And the fact that they weren't suggests that there was inadequate management of the staff and their obligations under the rules?

A. In relation to those components of the healthcare, yes.

Q. Yes?

A. Yes.

Q. That exposed vulnerable detainees at risk of harm to further harm because they weren't being notified to the Home Office for their detention to be reviewed?

A. Yes.

Q. So, in terms of the way the system was structured, whether it was to do with the resources available to those safeguards or the management of the staff or of Home Office oversight or lack thereof, the system was effectively structured and operated in a way that could lead to abuse and ill-treatment, wasn't it?

A. Yes. So I think where I've said in my report that the healthcare was -- I think in my original report where I said that it appeared that the healthcare was adequate, I'm referring specifically to the physical healthcare. What I have come to the understanding of is that the protective mechanism that sits around that core is what is inadequate, and I agree with what you have said there, that, in the absence of any systematic protection around that, these failings have been able to arise as a consequence of that.

Q. Yes, and they have led to the abuse and ill-treatment of detainees, in particular in the cases that we have just been through in some detail?

A. They certainly haven't protected them from other people.

Q. Clearly, that abuse and ill-treatment is not limited to derogatory comments or physical harm; it clearly relates to mental health as well?

A. Yes, yes.

Q. You made some recommendations in your original report at 6.5.6. You said:

"The system for the use of rule 35 appears to be time consuming, complicated and inefficient. The whole process for rule 35 would benefit from a review in order to establish a more dynamic and efficient approach to detained persons considered to be at risk. Any

subsequent development of a new process would require a systematic approach to the education and training in its use."

Do you still hold that view?

A. Yes. I would add to that the understanding component of it because, as I say, the more that I've listened to the evidence and looked at the witness statements, it's clear that very few people who were delivering these -- apparently used to be responsible for delivering these healthcare -- these responsibilities don't understand the foundations as to why they're doing them.

Q. Yes, and their role within them?

A. And their role within them, yes.

Q. You say at 6.5.7:

"The process for sharing of information between stakeholders in relation to the rule 35 process appears to be reliant on systems which contribute to their inefficiency and inflexible nature. In the event that a review of the rule 35 and Adults at Risk policy does take place, consideration needs to be given for devising a system which addresses these issues."

You are still of that view?

A. Yes.

Q. You have also recommended, as we have discussed, better training to address all of the limbs of the rule?

A. Yes.
Q. And to address clearly the thresholds for completing of them?
A. Yes. I think -- I mean, it is fair to say I don't think that the rules themselves are fundamentally flawed. I don't think that at all. I think it's their execution that's flawed.
Q. You would no doubt recommend not just training but also a system of feedback and oversight about the quality of reports that are being created?
A. Absolutely. You know, life evolves and healthcare evolves, so, you know, I can imagine that even if a significant amount of work was done to correct a system which has been unaddressed for a considerable period of time, even if those measures were put in place, we will still learn. You know, things will change. The environment will change or the detained persons may change. So we would need to, you know, reflect those changes as we go forwards, in terms of the oversight, in terms of the policies and how we execute them.
Q. And to ensure that they're just operating adequately --
A. Yes.
Q. -- in terms of the quality of what's being done?
A. Yes.

Q. At page 60 of your supplemental report, you make a recommendation, or suggest a recommendation, in relation to -- it is noted as rule 35(1), but I think, given the context of the paragraph refers to "victims of torture", that may simply be a typo and you're actually talking about rule 35(3); is that right? On page 60 of your supplemental report?
A. Take me to the point there.
Q. So you say you recommend a change to "has deteriorated" instead of "assessing the likely impact of detention" and you refer to the context of evidence of torture?
A. So I think, if I'm not mistaken, this is in the original report, because I think --
Q. You may be right.
A. I think, when I re-read this -- no, supplemental report. Just remind me which page is that?
Q. I think it was page 60, but actually it may be page 59. Perhaps I can just ask you about the substance of the question?
A. I don't think I made the point particularly well when I re-read this. This is to do with the ability to predict. I don't think that I'm recommending that it should be changed to that.
Q. No, I see.
A. Do you see what I'm saying?

Q. That's what I wanted to ask you about.
A. I'm not saying that. It is --
Q. It is just easier to identify when something has deteriorated --
A. Absolutely.
Q. -- as opposed to the impact of detention on deterioration?
A. Than to predict it, absolutely.
Q. I see.
A. Yes.
Q. So you're certainly not advocating a "wait and see" approach for --
A. Absolutely not, no, no.
Q. And you agree that the rules should be precautionary in relation to all of the limbs?
A. Pre-emptive, definitely.
Q. I'm grateful. If we move on, then, to mental capacity, at page 67 of your supplemental report, you say that those who lack capacity to make decisions should not be overlooked and that they may self-neglect and they may raise associated risks -- may have raised associated risks of suicide or serious harm. Would you agree that people who may lack capacity may also be unable to advocate for themselves?
A. Yes.

Q. They may be unable to make decisions to engage with healthcare?
A. Yes.
Q. And they may be unable to attend medical appointments?
A. Of course, yes.
Q. Or to raise concerns about their treatment in detention?
A. Indeed, indeed.
Q. It is, therefore, important, in relation to those people, then, for healthcare to be proactive in identifying their needs, isn't it?
A. And assessing capacity --
Q. Yes, and identifying any health concerns?
A. -- or lack of capacity in relation to specific decisions.
Q. D1275, who we briefly mentioned this morning, is someone who lacked capacity to make decisions about his medical treatment, the conditions of detention or to instruct a solicitor. He was identified by wing officers, by detention staff, as requiring a mental health assessment, but that he may lack the capacity to attend appointments and to engage with healthcare. He missed 13 appointments and was discharged from the mental health caseload on three occasions. There doesn't appear to have been any visit to the wing to see him, to assess him or to find out why he failed to attend so

many appointments. He continued to be referred back to the mental health team but was discharged. Sandra Calver gave evidence that there is an assumption that it's the choice of the individual whether to attend a medical appointment or not. Would you agree with that generally?

A. Yes, autonomy is important in an adult. You're assuming that they have mental capacity.

Q. Yes. But, on this occasion, she accepted there doesn't appear to have been any consideration of capacity in the circumstances. Would you agree with that?

A. I would agree with that.

Q. That's, again, a quite serious concern, isn't it?

A. Yes.

Q. Where there were missed appointments which related to apparent concerns about his mental health and the need for assessment, there ought to have been a more proactive investigation into the reasons why he'd missed those appointments, oughtn't there?

A. Even if it was just to test capacity at that time for the reasons for him not attending. So you have reassured yourself clinically that that's been taken care of, rather than just assuming.

Q. Yes. As it turns out, D1275 was suffering from a schizoaffective disorder with some psychotic symptoms

and he was hospitalised in an inpatient psychiatric unit shortly after he was released from detention. Despite concerns about his capacity being raised by the detention staff on the wing, no mental capacity assessment was carried out by healthcare until after his lawyers obtained an independent report. It should have been, shouldn't it?

A. Yes.

Q. He was also, we now know, being used as a guinea pig for spice, for drugs?

A. Yes.

Q. And no concerns were raised by healthcare about his safety in detention or his vulnerability to exploitation in that way, and he suffered spice attacks several times whilst he was in Brook House. There was no provision within the IRC at the time to provide him with access to independent advocacy to assist him to access healthcare and his legal rights. Do you think that there should be such assistance in IRCs?

A. That's a good question. I mean, I think -- I would have hoped that the healthcare were those advocates. You know, I think that's how I would have viewed their role.

Q. Yes. Is there a role in addition for independent advocacy on the part of a detainee, given healthcare clearly have other considerations applying to their

role?

A. It is a good question, and I've wrestled with this in my own mind, because what one doesn't want to do is create an even more complex system where there are more silos and more barriers and hurdles to overcome. I think what is needed is more expertise, but it needs to be done in an integrated fashion, as I have kind of alluded to, whether it be within the Home Office or within the healthcare or both, but done in a way which addresses, or is able to be utilised in a way which addresses, the sharing of information aspects that we discussed earlier. But it's got to be integrated. It's got to be confluent.

Q. The danger with someone like D1275 is that he wasn't presenting as being unusual or disruptive or indeed overtly dangerous to self-harm or suicide. He effectively withdrew and although he was deteriorating, he clearly fell through the healthcare net. So the concern is that he hadn't reached that sort of threshold where healthcare were going to be cared about him and that that's where, potentially, an independent advocacy service would have assisted him. Do you have any comment on that?

A. It's really difficult for me to make a decision about something like that at this moment. I guess I'm also

aware of the fact, like you say, that the attention of the healthcare would have been deflected elsewhere, undoubtedly, with respect to, as you say, the ongoing use of psychoactive substances and the use of force and other things that were probably diverting them away. So it did -- as a result of these other things that we have talked about, these other failures, the attempt to manage complex people in this environment, you are then not able to address more wholly the needs of your population. So somebody like that would be more likely. So I still go back to the notion, I suppose, ultimately, that if you weren't deflected away or diverted away by -- or magnetised -- polarised towards people who were perhaps drawing particular attention to themselves in one form or another -- I don't mean that disrespectfully -- you are then not able to look out for those other people who aren't able to advocate for themselves.

Q. And they do, as he does, seems to have done, fall through a gap?

A. Sure.

Q. So if it is not happening in healthcare, it needs to be happening in some other form?

A. Yeah, I still think healthcare should be responsible. I can't get away from that. I certainly see that from

the prison side of things, in my experience. You have to take care of everybody.

Q. One thing that independent advocacy could provide over and above even what healthcare could provide if doing their jobs properly, advocating for their patients, is assistance with their detention decisions. In other words, their immigration cases. Which, again, they may lack capacity to make decisions about.

A. Yes.

Q. That wouldn't be a healthcare role, would it?

A. No, it wouldn't, and I think that's fair. Yes, you would want to avoid that further complication of the dual responsibility.

Q. And avoid the gap that it --

A. Yes.

Q. -- gives in terms of those who lack capacity to deal with their detention decisions?

A. Yes.

Q. That gap seems to have contributed to the harm that was caused to D1275, because he continued to deteriorate in detention whilst he lacked capacity to deal both with his treatment and attendance at medical appointments and also his immigration case?

A. Yes.

Q. The Home Office in July 2020 introduced a DSO04 of 2020

entitled "Mental vulnerability and immigration detention" to give guidance to ensure that the necessary support is offered to those who lack decision-making capacity. Theresa Schleicher from Medical Justice gave some evidence that the introduction of this DSO doesn't address the concerns about those who may lack mental capacity in detention because it makes no provision for the gap that has specifically been identified as the need for independent advocacy. She said that Medical Justice continue to see people in detention, including at Brook House, even 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 made for them. That's right, that continues to be a concern, doesn't it?

A. Yes.

MS SIMCOCK: That might, just ever so slightly early, be a good point to pause for a break. Can we say 15 minutes, so maybe 3.25 pm?

THE CHAIR: Thank you.

(3.08 pm)

(A short break)

(3.25 pm)

MS SIMCOCK: Doctor, I now want to look briefly at segregation and the use of E wing. We heard from

Sandra Calver that use of force was used to relocate people from the residential wings to E wing, including on vulnerable people who were at risk of self-harm. Is that your understanding as well?

A. Yes.

Q. Could we look, then, at the case of D2159. His medical record is <CJS007001> -- we can show that on the screen -- in relation to 5 April. We see from 5 April an entry that he appeared unwell, and he was on food and fluid refusal. He appeared to be urinating on the floor and the plan was for an ACDT, and the nurse had expressed their concerns.

The next entry, on the same day, notes that he had visited the detainee at 11.50, he was still uncommunicative, he had managed to carry out a blood pressure, which was 104 over 76 and a pulse of 55. He hadn't allowed any further observations to be taken of him physically, such as blood sugar, temperature or oxygen saturations, and the room smelled and it appeared that the detainee had been incontinent of urine on the floor. He asked an officer to find someone who could clean the floor, at least, to make it smell better and noted:

"This nurse is quite concerned over the detainee and his general welfare. Have asked if a psychiatrist ought

to assess him."

It was clear that he was unwell and a decision was taken by the clinical lead, Chrissie Williams, whose entry we see underneath that of Mr Little's on 5 April, that he should be moved to E wing in his own interests so he could be observed closely. It appeared he hadn't showered and self-neglect was noted. That decision also contained the note "restraints may be used" and that a doctor will review to continue each day with advanced directive.

There is nothing in the entry to indicate that the clinical lead, Nurse Williams, spoke to D1259 about relocating him for his protection; do you agree?

A. I agree.

Q. Chrissie Williams couldn't recall if she spoke to him about the reasons for his move, but she agreed she should have done. She said by "restraints may be used" she meant holding his hand to persuade him to come. "Restraints may be used" doesn't really convey holding his hand, does it?

A. No. No.

Q. It indicates either a use of force on him, a restraint --

A. Yes.

Q. -- or, indeed, the use of restraints such as handcuffs?

A. Yes.
Q. Is that what you would understand by that entry?
A. Absolutely. Yes, I would.
Q. As a consequence of the nurse's recommendation, a planned use of force was adopted, and we know that because we have the use of force form for that date, which, at page 2, says it was a planned use of force to prevent self-harm. He was put in an inverted wrist hold, an arm hold or lock, and he was handcuffed for five minutes, and, again, we know that from the use of force form at page 3.
It was a four-person control and restraint in full PPE, including the use of a shield, and at one point he appeared to be resisting because he dropped to his knees, but that could also have been because he was too weak from food and fluid refusal, couldn't it?
A. As evidenced in part by his low blood pressure.
Q. Mr Collier, the inquiry's use of force expert, has looked at this incident, and he criticises the use of force on someone in such a condition due to food and fluid refusal as being unnecessary and disproportionate to the risk that he presented. He particularly says that the use of the shield was unnecessary, handcuffs were not appropriate, full PPE was unnecessary, and, again, referred to his physical condition as meaning

that he presented very little risk to staff and, therefore, the use of force was disproportionate.
In this case, the reason force seems to have been used, again, was because healthcare recommended or at least approved it, doesn't it?
A. Yes.
Q. His condition, as a result of food and fluid refusal, doesn't appear to have been taken into account by those making the decision to use force, does it?
A. Nor his capacity, mental capacity.
Q. Indeed. Nor his mental capacity. This wasn't a case where a rule 35(1) or rule 35(2) report was done. Should they have been?
A. Certainly rule 35(1). Rule 35(2), he's not, at this point in time, indicated that he's about to self-harm. But on the basis of the neglect and the food and fluid apparent refusal aspect of it -- we don't know at this stage, from the information I've been given, whether that was intentional or unintentional because of the lack of capacity. It could be unintentional food and fluid refusal. I would say, yes, a rule 35(2) should have been considered.
Q. No mental health assessment was done. It should have been, shouldn't it?
A. Yes.

Q. Chrissie Williams accepted in her evidence that the use of force was wrong and that she should have raised concerns about a use of force prior to it being done. Would you agree with that?
A. Yes. I just question, it is not something that would ordinarily -- I would expect to come across from a nurse unless asked. So, "Can we use use of force? We would need to use use of force?" The whole justification thing is not clearly explained at all, let alone the sanctioning of it.
Q. Would you agree that, in all those respects we have just been through, there was a series of failures in the safeguards which led to him being abused and ill-treated?
A. Yes.
Q. In particular, by a use of force that was unnecessary and excessive?
A. Yes, and disproportionate. Yes.
Q. In relation to D1527, we considered his case before the break in relation to the incident and in relation to Jo Buss, but he was also a person who was managed on E wing under constant watch on an ACDT, wasn't he?
A. Yes.
Q. He is another illustration of the use of segregation in relation to managing self-harm, suicidal ideation and

mental ill-health?
A. Yes.
Q. Dr Bingham's view was that, in his case, it was an inappropriate means of managing his distress and the symptoms of mental health problems and self-harm. Do you agree?
A. Yes. Yes.
Q. Again, it seems to be that segregation is what's done. Recourse is taken to segregation not as a last resort, but as a first resort, effectively?
A. I don't know about a first resort, but it just seems to be the custom and practice in place that "That is what we will do next".
Q. Because they don't know what else to do?
A. Yes. Or that they have any other mechanisms, apparently.
Q. But in the absence of the use of rule 35?
A. Yes, or a healthcare unit where somebody can be more closely observed. Although I heard the evidence that even somebody on constant supervision could still, you know, access other parts of the immigration removal centre, so thereby not segregating them excessively. I'm not sure I've seen the evidence that shows that that was done consistently for all of the people that were ever located in that unit.

Q. That's particularly of concern because, as we have touched upon previously, segregation and isolation are factors that exacerbate mental health problems in some cases?
A. In some cases, definitely.
Q. They can cause deterioration in many mental health conditions, including those that we see as prevalent in IRCs, such as PTSD, depression, anxiety?
A. Yes.
Q. Is that right?
A. Yes.
Q. They are associated, that is, segregation and isolation are factors associated with increased thoughts of self-harm and thoughts of suicide related to an environment that's socially isolating. Would you agree with that?
A. Yes, and devoid of stimulation.
Q. So what is being carried out as a response to those types of underlying conditions and incidents of self-harm actually exacerbates that behaviour; is that your understanding?
A. I would feel there is a high level of risk of that, yes, absolutely.
Q. Dr Bingham said in evidence that what's really needed instead is de-escalation and a therapeutic intervention.

Would you agree?
A. Absolutely, yes.
Q. She gave evidence, again, that if someone is so unwell as to need to be segregated, that suggests that they are -- they really shouldn't be in detention in the first place?
A. Yes, I think certainly that's where the rule 35s should kick in, so that you're notifying the Home Office that this is a measure that you've had to take because of that deterioration, and while that review of detention is taking place, it may be that, for that short -- hopefully short -- period of time that may be necessary, and I can't disagree with that because they don't have any other options. But it certainly doesn't seem to be the process that was followed. So, in other words, that use then became, in its own way, extended and overutilised.
Q. Causing harm?
A. Causing harm, yes.
Q. Healthcare staff, in D1527's case, Dr Bingham thought, should have been raising concerns and contraindications to the use of segregation for him. Do you agree?
A. Yes, I think so. Yes.
Q. In relation to food and fluid refusal, again, D1527's case is an example of someone with underlying mental

health and self-harm issues going through some lengthy periods of food and fluid refusal. Have you seen that from the records?
A. Yes.
Q. We have heard that there may have been a tendency not really to explore the reasons for food and fluid refusal in Brook House at the time and that observations were effectively primarily based upon basic physical observations?
A. Yes.
Q. Is that your understanding?
A. Yes, and where the detainee consented to those observations.
Q. It was often assumed that food and fluid refusal was a protest or attention-seeking behaviour. Did you see evidence of that?
A. Certainly, yes.
Q. It wasn't particularly clinically investigated, in terms of exploring the underlying reasons or causes?
A. No, it wasn't.
Q. It could be a sign of distress?
A. It could be, yes.
Q. There can be possible psychological causes for food and fluid refusal?
A. And organic causes, yes.

Q. And, depending upon the cause, it may require a different response?
A. Yes.
Q. It generally wasn't considered in conjunction with a risk of self-harm, was it?
A. No. No, it wasn't.
Q. It should have been, do you think?
A. Yes.
Q. It didn't seem to also be connected to consideration of the Adults at Risk policy, did it?
A. No.
Q. Again, there seemed to be a disconnect there?
A. (Witness nods).
Q. Or indeed with rule 35. Food and fluid refusal wasn't leading to a consideration of rule 35(1) or rule 35(2) reports?
A. It wasn't.
Q. So, again, a disconnect. It should have been considered, shouldn't it?
A. Yes, it should.
Q. In D1527's case, his repeated and prolonged periods of food and fluid refusal should have prompted consideration of a rule 35(1) report, in your view?
A. Yes. And that may have needed to have been on a repeated basis.

Q. Yes, at each stage, and with ongoing review?
A. Yes.
Q. You say at paragraph 4.7.5 at page 50 of your supplemental report:
"Within the case study for D1527 there was an extended period of apparent food refusal which was also managed under the ACDT process. In my opinion, the material provided demonstrated a deterioration in D1527's mental health following the rule 35(3) report and the subsequent response from the Home Office stating that detention was being maintained. It's not clear from this case as to the reason why there was no further escalation to review or provide a rule 35(1) or rule 35(2) report to notify the Home Office of D1527's further issues following this decision."
It is possible to speculate that, as a consequence of the fact that, where there was a response to the rule 35 from the Home Office stated that D1527 was on an open ACDT and that he was on treatment for depression, the healthcare staff felt there would be no rationale for re-presenting further information to the Home Office despite the apparent deterioration. Nevertheless, they should have done, shouldn't they?
A. Yes.
Q. "This case highlights the concern that there was no

appropriate and dynamic approach to the use of the rule 35 system given that despite D1527's prolonged food and fluid refusal as these concerns were not relayed to the Home Office."
So there also doesn't seem to have been any consideration of his capacity, does there?
A. No.
Q. And there doesn't routinely seem to have been consideration of a person's capacity in relation to food and fluid refusal cases?
A. Certainly not documented.
Q. You would expect that if a capacity assessment had been done, it would be documented, wouldn't you?
A. Yes, absolutely.
Q. That should routinely have been happening, shouldn't it, in cases of food and fluid refusal?
A. Yes.
Q. Moving on, I just want to deal with some of the further recommendations that you made in your report, please. You say in your original report at paragraph 6.5.16, and also in your supplemental report at pages 61 to 62, that independent medical assessors may be a route for the Home Office to gain clinical input and assistance in relation to these types of decisions; is that right?
A. Yes.

Q. In your original report, you suggested that a system for providing the support of independent medical advisors within the Home Office could be used to consider medical issues prior to detention, and you mentioned that this morning?
A. Yes.
Q. Is that right?
A. Yes.
Q. You also recommended, at page 62 of your supplemental report, that it would be helpful for the Home Office to review information prior to arriving in detention so as to make decisions as to detention about Adults at Risk?
A. Yes.
Q. Is that right?
A. Yes.
Q. So this proposal, primarily, its purpose is to ensure that potentially at risk people are screened out sooner rather than later; is that right?
A. "Screened out" meaning not coming to detention in the first place, yes.
Q. Exactly, screened out of the entire process?
A. Yes.
Q. So that they don't come into detention at all?
A. Yes.
Q. And so aren't exposed to the likely harm that vulnerable

people experience in detention?
A. Indeed.
Q. Effectively so that they're not exposed to any risk posed by detention?
A. Indeed.
Q. Once someone is in detention, though, is there a role for independent medical advisors at the Home Office in that situation?
A. I think -- I mean, I think the key here is -- and the analogy, I think I may have mentioned in one of the reports, is around something like the DVLA where they have medical advisors. So, as a GP, if I'm not sure about somebody's fitness to drive, I can contact another doctor and speak to them about that. That doctor has the expertise and understanding around fitness to drive and the medical condition's impact upon that and whether that person is still driving or needs to regain their licence. I think the value of having medical advisors within the Home Office, albeit independent, because we are -- as doctors, you know, we have to uphold our own independence generally, I can see the conflict there around, you know, being the voice of the Home Office, but you're speaking doctor to doctor. Clinician to clinician I think has a lot of weight to it and adds something to the whole system there or could

add something to the system there, so that you're challenging back to say, "This doesn't have enough information" or, "What did you mean by this? Can you provide more information, or can you provide an update in relation to the information that you have sent through?"

Q. You would accept that it is important for doctors, and indeed healthcare staff, to review a person's presentation over time? Indeed, that's been one of the criticisms you've had --

A. Yes.

Q. -- that there is no system for doing that?

A. No.

Q. Would it be challenging for a clinician who has no clinical involvement with a detainee to be able to keep his presentation under review once someone is in detention or would you view that, still, the doctor in the IRC would still be fulfilling that role?

A. What do you mean by that, sorry?

Q. If you are talking about independent medical advisors to the Home Office.

A. Well, I think, if you are being provided with the information on a regular basis that says, "These are the people" -- you know, from an IRC side, "These are the people we are concerned about, or most concerned about,

quality and the consistency and, you know, the uptake of those mechanisms in the correct way.

Q. So it could be, effectively, some form of quality assurance and oversight?

A. Yes. At the moment, we have essentially a system where --

Q. There is nothing?

A. -- the author is the marker of their own homework.

Q. I see. So there could be a dual system in place for screening out of people due to independent medical advisors prior to detention and then a quality assurance and review and oversight mechanism of those independent advisors at the Home Office if someone came to be in detention but might still be considered vulnerable?

A. Yeah, and I suppose, thinking it through pragmatically, if there was a sufficient mechanism in place in order to divert away from detention in the first place, a bit like liaison and diversion happens in relation to people going into prison, that would be useful. Clearly, I could imagine that the Home Office doesn't necessarily have all of that information in front of them, or, based on what I've seen from the information provided, that that need to detain outweighs those factors, then detention has to happen, then it's what happens after that point that then feeds back into the process to say,

because of all of the things we have discussed today", whether it is the ACDT, food and fluid refusal, history of torture, significant mental health issues, whatever they may be, or deterioration, then you can track that and you can follow it. Ultimately, I would argue it's the responsibility of the healthcare provider to be doing that and those GPs essentially are leading that process, or should be leading that process, but then you've got the interaction with that -- if you like, the equivalent in terms of line management at the Home Office to say, "Where are we with this?" Or "This has now changed. Does this affect your view on ongoing detention?".

Q. Because, of course, independent medical advisors at the Home Office would still be reliant on that third party information from the IRC, wouldn't they?

A. Yes.

Q. So that side of things would have to be working effectively?

A. It would, but I think, in a way, I guess -- if the system was working effectively -- if the system had been working effectively, you wouldn't need those medical advisors within the Home Office, and I think certainly, to begin with, until the system was working effectively, that could be an essential component of ensuring that

"Okay, we have gathered more information. This is the substance contained within a rule 35(1), (2) or (3), or even the rule 34". All of those mechanisms then kick in properly.

Q. So it would be a way of ensuring the adequate operating of rules 34 and 35 under all of the limbs of the rules?

A. Yes, and I think it also sends a red flag to those people working inside the health -- in the healthcare provider in the immigration removal centre, that, you know, we have had to do this, we appreciate there are some risks associated with it, and you need to take additional care there. I know we've talked about what that means for those people who perhaps slip under the net, but, nonetheless, if you are highlighted as to what those risks are at the outset, it puts an additional level of safety around the system.

Q. That system would also need, clearly, a proper system for ongoing review and follow-up --

A. Yes.

Q. -- of those who had been seen?

A. Yes. I mean, that's a very difficult system to configure because, of course, things change very dramatically within -- you know, it could be hours or days, and, you know, I would hesitate to put a timeframe on something like that.

Q. It would also be beneficial to formally and systemically link the ACDT system with the completion of rule 35(1) and (2) reports, wouldn't it?
A. Yes, it would, yes.
Q. And indeed to, again, formally and systemically link the food and fluid refusal aspect to the completion of rule 35 reports under limbs 1 and 2?
A. Yes.
Q. You have --
A. And use of force.
Q. And use of force in relation to, particularly, self-harm?
A. Yes.
Q. Finally, Doctor, I'd just like to ask you about some evidence that Dr Bingham gave that there is a link between the failure of all of these systems and safeguards and the mistreatment of detainees, and that -- what she said was that it's impossible to really separate these issues:
"Answer: ... 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."
She said:
"It's a perfect storm, and, in that situation, we have people that are then unqualified to manage. Their only recourse is to 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".
Do you have any particular comment upon that view? What's your view as to the link between these failures and the incidents -- the type of incidents of mistreatment that we see captured on Panorama?
A. I think yes, I mean, I agree with what Dr Bingham has said there and I certainly see that that is what -- that is the apparent practice that seems to have been allowed to grow in this environment.
Q. And to continue?
A. And to continue. And, you know, at what appears to be

significant harm to detained persons who, as you started at the outset, are there on an administrative basis rather than a punitive basis. We appreciate --
Q. And without a time limit.
A. And without a time limit. I appreciate that, you know, deprivation of liberty in the prisons' cases is the punishment, not the deprivation of healthcare. I think what we are seeing here seems to be a deprivation of safeguards that is contributing.
MS SIMCOCK: Thank you. Chair, I don't have any further questions for this witness. Do you have any questions?
Questions from THE CHAIR
THE CHAIR: Thank you very much, Ms Simcock. Thank you, Dr Hard. I do just have one question, just in relation to, obviously, you have a lot of experience of clinical care in a prison setting. And you talked a little bit about the appropriate setting up of resource to actually provide what is needed in an IRC setting. I'm just interested in your -- if you have any reflections on it. From what you have seen of the structure at Brook House, is that akin to the kind of way that healthcare would be set up in a prison, albeit there is no in-bed healthcare provision?
A. In-bed patient.
THE CHAIR: Yes.

A. It does seem to be sympathetic to that experience that I have had in prisons and is prioritised towards that sort of level of need, rather than the safeguarding component. As I was trying to say at the beginning, that seemed to be more of a footnote, the safeguarding component, to the healthcare provision. As I said, I can see the conflict there. Something very detailed and involved, like doing a rule 35(3) report, which would essentially, in my mind, stop you in your tracks. If you discovered that, then what do you do with the rest of your clinic? I can see how a clinician, a GP, working in that environment would feel that's very difficult. They get a phone call from a nurse on the wing saying, "Somebody has just declared they are a victim of torture. What are we going to do?" I can see the complexity there. I haven't yet worked out how you would fix that. It's very complicated.
THE CHAIR: Thank you very much. I have no other questions for you. Thank you very much, Dr Hard. It's been a long day but it's been very important to hear your evidence. I very much appreciate it, thank you.
Ms Simcock?
(The witness withdrew)
MS SIMCOCK: Thank you. So at 10.00 am tomorrow, we will hear from Professor Bosworth.

THE CHAIR: Thank you.
(3.58 pm)
(The hearing was adjourned to
Tuesday, 29 March 2022 at 10.00 am)

I N D E X

DR JAMES JESSE HARD (affirmed) 1

Examination by MS SIMCOCK 1

Questions from THE CHAIR 179

A
A&E 73:4 93:4
ability 33:17 49:9 150:21
ablation 92:23
able 8:24 11:13 31:12 34:11 59:20 60:24 75:5 80:24 106:11 122:14 124:3,7 124:12,24 135:8 136:25 142:21 147:9 155:10 156:9,16,17 173:15
abnormal 83:25 92:24
absence 12:8 32:11,15 39:24 41:8,20 43:21,23 45:21 58:6 82:5 82:11 100:9 101:22 112:19 138:18,19 144:16 147:8 164:17
absent 69:13
absolutely 8:15 17:15 21:25 28:9 28:15 34:7 42:20 43:2 44:6 46:7 60:16 64:11 65:8 65:23 70:5 72:3 77:24 82:1 89:4 98:22 104:1,10 106:10 112:14 115:23 118:18 120:4,25 121:13 121:22 124:1 127:22 128:13 130:18 137:11 142:25 149:11 151:5,8,13 161:3 165:23 166:2 170:14
abuse 146:25 147:11,15
abused 74:23 163:13
abuses 178:15
accept 73:20 173:7
acceptance 40:7
accepted 57:22 67:8,23 78:13 81:4 90:11 120:25 123:20 124:6 127:9 128:18 129:14 130:11 153:9 163:1
accepts 128:2
access 63:14 85:25 143:4 154:16,17 164:21
accommodate 64:16
accords 20:12 63:19 77:17
account 31:7 45:3 85:6,7 94:22 123:14 162:8
accounted 39:7
ACCT 113:11
accurate 100:18
accurately 23:19 131:25 134:6 136:17
ACDT 5:9 28:4 65:24 71:8,16 73:10 74:2 78:19 79:18 80:12,17 82:25 102:1 103:17,24 104:13 111:7 113:14,17 113:23 114:3,9 115:12 116:20 131:8 159:11 163:22 169:7,19 174:2 177:2
ACDTs 57:18,24 58:4 69:17 78:9 78:12,22
achieve 61:3
acquired 35:5
act 11:2 82:22 100:21
acting 140:1
action 87:17 118:9 127:19 130:2
actions 98:6,7 99:3 123:4 126:3
active 117:25
actively 22:13
activities 46:10
actual 21:13 55:5 57:11,15 85:10
acumen 33:16
acute 11:5 36:13
acutely 42:4
ad 31:1 43:6,18,22
add 7:1 94:18 148:5 173:1
addition 154:23
additional 6:21 7:24 14:15 50:12 51:21 68:7,17 85:5 92:10 94:19 95:10 103:22 106:19 115:15 136:15 145:22 176:12,15
additionally 68:10 83:3 138:20
address 10:25 16:5 39:14 40:14 41:10 79:23 92:9 148:25 149:2 156:9 158:6
addressed 11:9,25 21:9 39:22
addresses 148:21 155:9,10
addressing 12:21 33:9
adds 172:25
adduced 1:20
adequate 19:5 27:21 35:12,18 43:6 80:6 132:5 132:6 146:6 147:4 176:5
adequately 109:20 124:17 125:20,25 134:2 149:22
adjourned 181:3
adjournment 113:6
adjunct 109:7
administrative 6:15 7:20 179:2
admission 10:19 23:9 73:10
admissions 123:9
adopted 161:5
adult 20:16 40:9 55:25 101:16 109:17 153:7
Adults 5:3 6:22 31:11 57:9,13 60:14 148:19 168:10 171:12
advanced 160:9
advice 3:11,13 95:9
advise 42:12
advised 15:19
advisor 3:9
advisors 171:2 172:7,12,19 173:20 174:14,23 175:11,13
advocacy 154:17 154:24 155:21 157:3 158:9
advocate 7:21 151:24 156:17
advocates 154:21
advocating 106:9 151:11 157:5
affect 174:12
affirmed 1:4 181:9
Afghanistan 141:4
agitated 85:23 128:21
ago 88:9
agree 6:11 8:16 12:7,12 14:5 16:12 17:14 18:16 22:4,7 23:16,23 27:16 54:16 56:16 58:3 59:2 62:3,12,21 62:25 63:21,25 64:17,18 65:7,10 65:12,19 66:2,7 69:3 72:18 75:2 78:16 81:6 84:13 84:14 86:24 88:8 89:3,13 90:4,14 92:6 93:10 97:20 118:17,23 121:2 121:21 124:10 128:20 132:8 137:5,14 139:8 147:7 151:14,22 153:5,11,12 160:13,14 163:4 163:11 164:6 165:15 166:1,22 178:20
agreed 160:16
agreement 123:22 123:24,25
aim 6:23
aimed 65:16
airline 87:15,22
airway 124:9
akin 179:21
albeit 172:19 179:22
alcohol 11:6
alerted 84:10
alike 25:7
allocate 19:23 35:22
allocated 18:22
allocation 35:17
allowed 159:17 178:22
alluded 87:6 155:7
alongside 38:24 80:2 139:16
alternative 79:21
amount 149:13
analogy 172:10
and/or 11:5 102:20
angry 131:18 132:7 133:14 134:13
answer 47:24 59:13,18 60:4 94:7 107:1,16,17 107:22 177:20
anti 107:22
anti-epileptic 11:4

anticipated 123:13
antidepressant 106:22,24 107:2 107:9,15,19 108:23 110:16,20 110:23
antidepressants 104:23 107:21 108:6 110:14
anxiety 41:1,16 42:2 61:18 64:2 68:13 135:9 165:8
anxious 144:13
apart 42:22
apparent 48:23 49:8,13 50:1,18 50:25 59:7 83:4 102:6 127:17 153:16 162:17 169:6,22 178:22
apparently 47:10 54:5 70:16 75:4 83:1 85:24 114:24 115:13,16 148:9 164:16
appear 19:18 28:22 30:24 31:13 40:6 46:4 51:6 52:6 56:25 59:6 67:7 68:19 85:6 104:14 109:14 113:19 143:6 144:23 145:18 152:24 153:10 162:8
appeared 34:10 52:9 54:5 56:17 56:18,19 58:21 58:25 65:14 74:3 76:2 99:10 101:22 137:21,25 139:25 147:3 159:9,10,19 160:6 161:14
appears 14:6 16:18 17:15,18 31:3 32:18 37:2 40:19,22 49:23 50:6,16 52:17 55:2 66:4 69:23 72:17 78:2 81:12 81:21 85:25 91:21 97:18 103:20 104:17 108:9 109:21 122:10 127:19 129:24 137:15 140:16 145:1 147:21 148:16 178:25
application 141:18
applied 58:2 60:20 69:15 81:5 82:3
applying 60:18 129:10 154:25
appointment 9:12 10:8 11:7 14:3,5 14:24 15:4,14,17 15:21,24 16:3,7 16:11,19,21 17:7 18:21 19:14 20:4 21:20 29:23 35:17,23 37:1 102:3,13,16,18 105:8 106:15,25 108:11,13,17,22 109:5 111:6 114:21 115:2 153:5
appointments 15:7 15:20 18:12 109:18 152:4,21 152:22 153:1,15 153:19 157:22
appreciate 19:25 26:1 35:20 45:15 45:18 62:14 176:10 179:3,5 180:21
appreciation 137:2
approach 28:17 29:4 33:9 47:1 50:19 80:15 106:7 109:15 119:4 130:1 139:12,19 140:7 147:24 148:2 151:12 170:1
appropriate 13:3 31:15 34:15 35:8 49:12 53:3 60:1 61:7 63:5,16 64:15 74:13 83:18 112:24 129:22 145:18 161:24 170:1 179:17
appropriately 11:25 34:13 78:1 118:25
approval 81:21 97:19
approve 81:24 89:17,19
approved 76:2 88:17 105:13 162:5
approving 91:5 98:2
approximately 133:8
April 87:9 101:6 105:2,8 106:25 107:19 111:5,12 113:11,19 114:7 115:7,8,15,24 116:3,4,16 131:11 135:22 159:8,8 160:4
area 24:25 25:5,18 25:23 33:11 38:23 39:3 62:14 100:3
areas 3:14 55:10 132:9
arguably 20:21 35:2 107:7 114:22 120:21 122:11
argue 174:5
arises 105:20
arising 30:6 49:22
arm 161:9
arms 82:20
Army 141:3
arose 4:18 53:22
arranged 37:16
arrangements 20:6
arrest 88:1
arrival 4:24 9:1,8 9:10,13 11:19 14:3 15:9 16:17 115:4
arrived 113:10 141:12
arrives 9:4 21:2
arriving 4:20 171:11
arse 121:1
arterial 92:22
artery 83:24 84:22
articulate 86:12
ascertain 46:16
aside 134:3
asked 50:17 52:11 59:25 79:10 87:9 107:18,19 142:5 159:21,25 163:7
asking 80:4
asks 32:24
aspect 48:13 60:4 69:12 119:3 120:5 162:17 177:6
aspects 1:25 17:20 48:14 49:7 65:15 65:24 67:17 120:8 155:11
assaulted 74:22
assess 46:24 95:8 102:18 152:25 160:1
assessed 36:25 46:23 158:13,13
assessing 150:10 152:11
assessment 10:4 11:12,14 16:16 16:18 19:4,25 21:21 32:10,14 36:6 40:12 75:8 86:11 87:15 99:4 103:2 105:1 114:10 141:14 152:20 153:17 154:5 162:23 170:12
assessments 35:17 36:22 67:21 141:13
assessors 170:22
assist 3:17 55:15 154:17
assistance 154:19 157:6 170:23
assisted 155:22
associate 3:9
associated 151:21 151:21 165:12,13 176:11
association 64:22 66:16 67:6
assume 59:19
assumed 167:14
assuming 153:7,23
assumption 85:7 153:3
assurance 42:21 44:12 46:10,21 48:7 175:4,11
attacks 154:14
attempt 28:14 49:25 50:18 74:4 80:7 110:5 136:1 156:7
attempted 49:15 100:17 106:14 115:25 131:19 133:13
attempting 110:10
attempts 50:25 73:2 77:13 84:4
attend 16:11 102:4 103:2 123:17 129:2 152:4,20 152:25 153:4
attendance 142:7 157:22
attending 16:3 153:21
attention 27:4 156:1,14

attention-seeking 167:15
attitude 111:15
attitudes 111:22
audible 127:20
August 141:8
author 175:8
authorising 27:5
authority 112:5
automatic 49:24
autonomy 153:7
availability 25:17
available 8:17 22:15 65:11 71:10 103:4 146:21
avoid 157:12,14
avoided 118:25
awaiting 84:1 92:23 94:23
aware 37:8 61:23 63:6,7 73:5 77:15 82:9 89:25 98:4 103:14 106:2 156:1
awareness 33:17 34:1,20

B

baby 120:12
Bachelor 2:4
back 20:21 32:16 42:7 43:6,23 45:14 47:19 55:9 68:2 69:24 77:24 80:9 86:10 100:4 153:1 156:11 173:2 175:25
balance 145:19
balances 145:20
barriers 155:5
based 7:2 33:2 37:12 65:18 103:3 123:13 167:8 175:21
basic 14:9 34:11 167:8
basis 31:1 33:15 35:20 39:4 43:22 47:23 108:17 115:9 132:2 162:16 168:25 173:23 179:2,3
battery 116:1 131:19 133:11,12
bear 47:9
becoming 72:5
began 72:23
beginning 27:18 128:1,9 180:4
behalf 37:10 81:23 135:21
behaviour 66:10 86:23 100:8 165:20 167:15 178:5
behavioural 100:7
behaviours 65:19 178:3
Belda 73:11 74:11
believe 104:21 111:18
believed 14:13
Belmarsh 113:12
beneficial 34:1 177:1
benefit 66:14 147:23
bespoke 30:9,21
best 57:7 90:12,16 90:21 106:12
better 34:3 79:7 139:21 140:7,8 148:24 159:22
beyond 7:25
Bingham 17:6 48:2 62:6 64:14 77:8,20 79:25 86:21 88:25 91:9 92:2 165:24 166:20 177:15 178:20
Bingham's 6:3 164:3
bipolar 42:6
bit 10:5 17:1 25:6 37:7 58:24 64:8 84:14 119:21 129:25 175:17 179:16
blaming 134:15 135:3
blank 39:12 87:16 135:16
blood 83:25 159:15,18 161:17
body 38:18 56:5 136:4
boggles 135:2
book 29:23
booked 16:19,21
booking 17:7
Bosworth 180:25
bottom 19:11 23:2 23:3 26:18 60:24
boxes 14:12
breach 15:5,10
breaching 91:17
break 61:8,11 126:16 158:18,22 163:20
breathe 127:18 138:4
breathed 33:12
breathing 124:8 130:5 132:19
brief 136:13
briefly 3:2 4:17 12:5 22:20 26:17 27:18 72:15 82:17 126:6 152:15 158:24
bring 44:24 75:3
British 141:3 142:1
broadest 40:21
Brook 4:10 5:8,14 6:8 11:21 20:7 28:19 31:9 32:2 33:21 34:22 63:4 63:10,15 67:17 72:25 73:10,12 74:12,15 81:20 83:25 84:4 103:18,25 104:4 105:14 113:10,18 137:14 139:21 141:11 142:6,12 143:12,16 144:8 144:24 154:15 158:11 167:7 179:20
brought 27:3 73:4
bunny 120:12
Buss 120:7,13 121:9 123:7 126:21 128:2,18 129:8,13 130:10 131:9,24 133:3 135:20 163:21
busy 68:14
bypass 83:24 84:22
bypasses 92:22

C

C 70:12 75:24 76:13 77:1,4,22 78:4 83:9
C&R 88:23
CAA 88:4
call 126:23 180:13
called 50:10 133:7
Callum 97:3,6,12 98:18 122:2 130:10,12
Calver 16:13 18:12 57:22 63:12 67:8,23 68:21 73:22 76:3 76:19 78:13 81:4 81:19 89:25 153:3 159:1
Calver's 5:25
capacity 72:9 151:17,19,23 152:11,13,16,20 153:8,10,20 154:3,4 157:8,16 157:21 158:4,7 158:12 162:10,10 162:11,20 170:6 170:9,12 178:12
captured 178:19
cardiac 83:23,24 84:1,19 88:1,5 92:10,23,24 93:9 94:13,14,24 95:1
Cardiff 2:20 25:10
care 8:2 11:20 17:19,22 33:25 36:17 42:3 51:17 64:20 72:10 81:3 94:18 98:8 111:17 117:24,25 139:20 153:23 157:2 176:12 179:16
cared 155:20
careful 96:15
carefully 96:13
Caroline 2:25
carried 9:8 32:1,8 124:17 154:5 165:18
carry 19:6 22:17 26:20 27:6 31:12 101:23 123:21 140:25 159:15
carrying 96:24 123:20
case 14:6 18:1 22:10 49:7,23 51:12 58:15,20 58:24 59:5 72:14 72:21 76:13 82:14,15,16 84:9 84:17 91:22 92:5 96:16 109:9 112:25 113:8,10 115:16 117:2,6,9 136:18 137:11,21 143:21,24,25 145:12 157:23 159:6 162:3,11 163:19 164:3 166:20,25 168:21 169:5,12,25
caseload 152:23
cases 50:17 56:14 72:20 77:20 141:24 147:12 157:7 165:4,5 170:10,16 179:6
caseworkers 27:4 43:4,9
catheter 92:23

cause 71:19 73:7,7 118:7 165:6 168:1
caused 18:10,11 54:23 55:7 56:15 59:1 74:24 75:21 122:3 157:20
causes 79:24 167:19,23,25
Causing 166:18,19
CBT 63:13 71:11
cent 47:9 81:7 89:24 139:4
centre 4:9 5:2 6:5 6:22 7:10 9:2,4 10:10,14,20 15:9 25:3 26:9,14 48:22 58:17 61:16 94:20 107:12 164:22 176:9
centred 65:14 71:14
centres 3:5 4:7 8:4 30:14 63:15
certain 30:16 65:15,24 88:5
certainly 8:1 11:6 19:5 20:12 21:17 22:10 24:21 28:7 38:22 43:12 50:9 56:10 57:9 60:4 61:1 63:9,23 64:10 65:20 66:1 66:11 67:8 69:17 71:6 85:23 86:18 93:15,23 95:18 98:8 101:19 106:17 109:4 111:12 112:1 115:4 127:19 128:6,21,24 129:2 132:7,17 134:17 137:17,19 142:14 144:11 145:18 147:14 151:11 156:25 162:14 166:7,14 167:17 170:11 174:23 178:21
cetera 18:6 86:4 93:20
chair 1:3,21,22 2:22,25 61:7,9 112:23 113:2,4 123:11 126:13 158:20 179:10,12 179:13,25 180:18 181:1,13
challenge 43:11,23 84:14 110:16
challenged 120:14 121:16 130:16 131:5 140:3
challenging 173:2 173:14 178:4
chance 37:3 50:7
change 83:2 103:5 149:17,17,18 150:9 176:22
changed 51:9 117:19 150:23 174:12
changes 34:25 50:21 149:19
characterised 87:1
charitable 25:22
Charlie 129:9,18 130:3
Chaudhary 32:1 83:9 87:12 113:19
Chaudhary's 6:1
check 124:8
checked 146:2
checks 145:19
chest 92:25 93:1,2 93:2,3
choice 153:4
choke 121:10 126:22 132:3 134:4
choked 124:13
choking 126:24
Chrissie 160:3,15 163:1
Churcher 63:4 108:10
circumstances 7:16 16:22 20:19 27:10 31:15 50:3 51:7 53:3 73:25 79:18 80:8 82:2 83:3 102:25 103:5 121:23 125:21 126:1 153:11
CJS001002 133:2
CJS005534 135:13
CJS006045 22:22
CJS006120 10:13
CJS007001 159:7
clarity 30:7 48:4 53:8
clean 159:22
clear 9:18 10:2 30:11,12 58:13 75:6 105:1,6 118:13 121:9 124:25 142:15 144:9 148:8 160:2 169:11
clearly 9:16 14:7 17:24 23:18 26:17 32:24 44:1 47:6,8 48:2,17 50:3 51:16 52:1 56:13 70:13 83:17 85:18 89:10 91:20 95:11 98:3 119:12 120:2,23 120:25 123:11 132:14 134:2 137:21 139:11,23 140:4 147:15,16 149:2 154:25 155:18 163:9 175:19 176:17
clinic 180:11
clinical 1:13 3:11 3:16,21 7:11 9:7 10:2 12:4,9 16:6 22:13 26:5 33:16 36:2 66:5 67:14 67:16,19,21 79:23 80:21 96:6 109:3 133:4 134:9 135:6 138:13,19,22 145:25 160:3,12 170:23 173:15 179:15
clinically 23:11 61:17 64:1 107:2 135:7 153:22 167:18
clinician 172:24 172:24 173:14 180:11
clip 128:1,7,10,14 128:15
closely 160:6 164:19
closer 64:8 116:2
co-operative 139:18
cock 120:11
collaborative 139:19
colleagues 119:18
collective 30:18
collectively 27:25
College 2:5,6,22 63:20
Collier 98:23 161:18
Collier's 100:1,1
combat 99:25 141:2
come 9:15 10:5 19:22 24:11 25:9 28:12 31:20 39:20 42:7 44:8 47:8 55:3 56:11 58:24 59:8 79:3 116:2 122:16 138:5 147:5 160:18 163:6 171:23
comes 86:10,19
coming 7:3 14:14 14:17 35:19,22 43:5 117:9 122:9 137:1 143:17 171:19
commencement 28:19 104:13 113:17
comment 32:23 102:12 121:1 155:23 178:16
commented 30:8 30:21 84:8 101:21 108:15
comments 120:9 120:10 147:16
commissioned 3:17
common 33:7 42:2
commonly 14:13
communicated 105:3
community 73:1 95:4 142:3
compassion 33:6
complaining 92:25
complete 50:14 54:13 75:12 76:16 78:18 81:6 82:5,10 102:19 102:21 119:12 143:21 145:1,6
completed 12:25 21:21 22:9 38:1 42:17 51:3 53:2 74:5,6 77:12,22 82:3,5 83:9,12,15 100:14 101:6 103:3 114:8 116:9,9 136:16 136:17 145:5
completely 22:4 38:11 54:24 78:21 89:23 100:24 137:6,7
completes 81:10
completing 26:23 38:18 52:10 75:24 117:17 149:2
completion 58:22 177:2,6
complex 92:7 96:18 155:4

156:8
complexity 33:19 119:4 123:2 180:16
compliance 99:7
compliant 12:8 69:10
complicated 147:22 180:17
complication 157:12
complicit 120:24
comply 20:7
component 11:15 12:13,17 88:12 148:5 174:25 180:4,6
components 18:7 26:11 36:8 146:13
comprehensive 28:17 29:3
concern 21:7,11 21:24 32:4 47:6 47:13,14 68:25 71:23 76:23,24 77:23 79:1 81:11 87:20 91:4,23,24 94:2 96:7 98:4 98:11,12 99:2 109:14 122:4,21 125:6 127:2,6,15 127:22 128:10,25 129:16,20 136:15 138:16 139:5 153:13 155:19 158:15 165:1 169:25
concerned 73:21 90:2 99:8 118:15 129:16 159:24 173:25,25
concerning 12:11 54:14 130:10
concerns 39:25 40:13 41:10 76:21 77:2,21 80:24 81:18 83:10 89:6,11,16 90:6 92:4 95:20 152:6,12 153:16 154:3,12 158:6 159:12 163:3 166:21 170:3
conclude 53:6
concluded 31:21 98:25 101:15 115:8
conclusion 29:7 43:5 44:8
conclusions 32:9
condition 51:9 59:8 83:11,23 87:24,25 88:10 88:22 89:12 91:1 92:3,20 93:7,8 94:13,14 95:2 99:9 101:25 142:11 143:3 161:20,25 162:7
condition's 172:16
conditions 7:5 36:14 41:3,17 94:8 152:17 165:7,19
conduct 140:2
conducted 140:20
confidence 112:5
confidentiality 91:4,17
configure 176:22
configured 63:23
confinement 178:11
confirm 87:9
confirmed 37:25 66:9 141:6
conflict 17:16 36:14,16 40:17 41:23 55:9 84:15 85:19 93:23 172:22 180:7
confluent 155:13
confounding 88:2
conjunction 168:4
connected 56:19 69:24 168:9
connection 70:2
consent 15:14,16 23:7 91:19
consented 167:12
consequence 35:3 55:2 56:22 71:2 114:24 147:10 161:4 169:16
consequences 11:4 38:6 40:15 43:16 98:6
consider 6:4 21:1 30:4 44:13 51:9 52:2,3 60:15 92:8 107:20,25 108:2 112:17 123:12 171:3
considerable 16:21 18:25 110:20 117:14 138:16 139:5 149:14
consideration 12:10 22:3 65:4 69:21 70:6 78:23 87:8 99:9 107:18 108:23,25 116:25 138:10 148:20 153:10 168:9,15 168:23 170:6,9
considerations 154:25
considered 13:17 16:15 72:21 92:19 93:12,15 93:16 98:24 107:6 108:8,9 109:6,16 110:17 111:7 117:16 123:16 142:14 147:25 162:22 163:19 168:4,19 175:14
considering 33:2 53:21 67:22 80:12 94:2 109:11 136:20
consistency 175:1
consistent 109:15 144:10 145:1
consistently 69:14 164:24
constant 57:24 78:12,12,22 81:14 131:17 133:6,8,19 163:22 164:20
consultation 107:21
consuming 147:22
contact 24:10 172:13
contain 90:25
contained 76:14 85:17 160:8 176:2
containment 71:15
contains 26:23
contemporaneous 5:7
content 76:10
context 6:20 99:14 145:8 150:4,11
continue 2:11 40:5 45:6 51:16 101:24 158:10 160:9 178:24,25
continued 73:21 116:19,20,23 143:25 153:1 157:20
continues 82:12,13 133:19 158:14
continuing 8:13 138:17
contraindication 94:3 96:7
contraindications 89:6,16 90:6 92:5 95:24 166:21
contrary 123:8
contribute 61:1 148:17
contributed 3:22 54:9 110:9,14 112:18 157:19
contributing 4:5 179:9
control 93:20 96:22 161:12
controlled 85:17
convenience 66:13 87:7 105:23
conversation 95:13 130:9
convey 132:1 134:6 136:13 160:19
conveyed 44:17
Cool 97:12
Coordinating 3:3
coordination 144:2
copies 1:18 97:9
coping 45:1
copy 97:16
core 41:15 147:6
coronary 55:14 83:24 84:22 92:22
coroner 4:13
correct 4:16 43:25 69:19 85:22 89:9 106:4 118:11 145:20 149:13 175:2
correctly 140:20
corresponding 83:1 138:10
countering 140:5
counterintuitive 54:24
country 74:17 84:20
couple 25:10 75:3 97:3,9 126:10
course 16:10 25:21 50:8 52:23 91:17 96:1 100:4 123:12 129:15 145:4 152:5 174:14 176:22
court 6:14
cover 2:1 28:4
covered 117:6
covers 27:18
CPS000009

131:10
CPT 39:2
create 28:1 31:6 155:3
created 37:23 48:15 149:10
criteria 60:12 85:12 88:5
criticise 73:23
criticises 161:19
criticisms 173:10
cross-refer 141:22
crucial 11:19
crying 144:12
Cs 70:10 76:10 77:10,12
CSU 64:20 67:12
cul-de-sac 69:24
cultural 119:3
current 61:21 95:10 123:13
currently 21:1 63:23 92:23
cursory 19:4
custodial 2:8 33:25 66:4,25 71:16 79:19 80:16,23 87:7 96:2,16 139:13 139:15 140:1,6
custody 3:18 10:24
custom 53:24 60:25 164:12
cuts 82:20 115:14

D

D 181:7
D1259 160:12
D1275 152:15 153:24 155:14 157:20
D1275's 72:14
D1525's 122:8
D1527 59:5 113:9 113:10,18,23 115:24 117:9 118:12,23 121:20 122:17 126:22 128:6,15 129:10 129:14 131:17 134:3 136:8 144:25 163:19 169:5,18
D1527's 115:11,16 121:10 123:22 132:1 137:11 166:20,24 168:21 169:9,14 170:2
D1914 59:5 82:14 82:19 87:10,12 96:25 98:15 99:2 99:9 100:15,17 145:1
D1914's 91:1 92:5
D2159 159:6
D643 141:2,2 142:1 143:12 144:5
D643's 142:19
D687 59:5 101:3,5 101:11,16,20 103:12,17,20 104:17 110:13 111:9,22 144:25
D687's 101:25 105:16 110:4 111:5
D801 58:20 72:21 74:15 77:11 144:25
daily 35:20
Dalia 133:10
danger 155:14
dangerous 155:16
date 135:22 161:6
dated 26:14
Dave 97:5,7,13 98:17
day 11:15 15:21 19:21,22,24 35:18,23 36:6 37:2 87:12,15 111:3 113:18 115:24 116:7,15 145:11,11 159:13 160:9 180:20
day-to-day 146:6
days 4:20,23 9:20 10:24 74:24 111:13 114:7,18 141:7,8,9,10 143:13 176:24
DCO 98:15
DCOs 96:24 97:18
de-escalation 99:25 165:25
deal 1:24 24:12 36:3 48:19 81:25 86:9 120:5 157:16,21 170:18
dealing 17:4 27:12 33:18 65:16
deals 26:21,22 27:6,11 49:2 64:21
dealt 18:7 32:12 46:8 82:16 83:20 84:8 101:3
death 3:18 4:14 92:18
December 141:10 141:12
decide 90:3
decided 53:25 108:5
decision 12:10 51:15,16 78:3,3 96:1,4,5 101:17 101:19 105:18 106:5,17 155:24 160:2,7 162:9 169:15
decision-making 158:3
decisions 60:17 72:9 151:19 152:1,14,16 157:6,8,17 170:24 171:12
declared 30:2 46:20 114:20 180:14
dedicated 34:22
defending 98:6
defer 36:2
deficiencies 13:18 31:2 37:21 117:12
deficiency 21:15
deficient 132:9
define 108:6
definitely 89:19 109:12 151:16 165:5
definition 61:22
deflect 36:3 55:16
deflected 156:2,12
deflecting 107:7
dehydration 4:22
delay 16:22 17:8 17:12 20:5,20 36:24 58:22
delayed 69:11 114:24
delaying 17:3
delays 12:19 16:24 18:8 36:7,8,21 37:17 54:10
deliberate 86:17
deliberately 86:16 87:4
deliver 20:2 26:6 61:4
delivered 25:13
delivering 148:8,9
delivery 17:16,17 17:22 36:17
demeanour 131:21
demonstrated 118:19 169:8
demonstrates 98:17
demonstrating 33:8
departures 22:23
depending 168:1
depends 117:20 120:20
depressed 109:6 144:13
depression 41:1,16 42:2 61:18 62:18 64:2 72:4 108:7 109:8 165:8 169:19
deprivation 179:6 179:7,8
depth 143:8
derived 113:15
derogatory 118:19 121:4,5 147:16
describe 134:14,17
described 14:9 19:14 78:19 104:23 110:9 111:15 123:8 126:23 127:12 144:11
describes 61:25 110:6 111:22
describing 60:6
description 38:21 110:4 126:24
desensitisation 33:6 80:10
desensitised 33:14
designed 13:6 56:1 57:14 79:20 143:22
despite 60:11 90:8 100:17 101:15 116:7,21 119:13 142:20 154:2 169:22 170:2
detail 10:5 13:23 24:12 28:22 31:20 39:20 42:23 47:17 58:24 59:9 109:2 113:9 116:3 117:14 122:17 132:10 147:13
detailed 180:7
details 82:18
detain 7:16 175:23
detained 5:16 8:14 10:16 11:20,21 12:23 15:25 20:24 21:2 22:8 22:11 23:13,19 24:10 28:23 29:1 34:2 37:10 44:18 44:25 46:14 47:12 48:23 49:4 49:13,24 51:7 59:8 66:14 67:16

73:8 74:12 80:21 84:25 85:3 87:10 87:13 89:12 91:18 98:13 102:19 103:1 105:25 106:12 107:4 109:16 112:12 114:20 117:15 129:21 134:15 135:4 138:4 139:20 141:6 143:12 147:25 149:17 179:1
detained-person... 65:21
detainee 13:14 15:19 21:18 22:23 52:11 88:20 118:12 135:16,24 154:24 159:14,20,24 167:12 173:15
detainee's 9:1,8 15:9 94:9
detainees 6:13 14:17 15:13 21:12 23:5,8 27:3 57:18 60:18 61:15,17 63:13 64:11,16 67:12 71:3 77:6 78:11 143:11,22 146:16 147:12 177:17
detaining 73:7
detect 51:18
detected 20:15 109:20
detecting 56:20 68:3
detection 12:19 16:25
detention 5:2 6:10 6:18,20,22,24 7:13,14,15 8:10 8:12,20 10:9,13 10:20 11:19 12:11,16,21 13:2 13:10 16:23 17:11 20:17,18 20:19,23 21:2,13 26:14 27:6,9 32:10,21,24 33:2 36:25 37:4,4,12 38:16 39:15 40:2 40:5 41:22 43:17 43:20 44:14,19 44:24 45:1,2,6,13 45:22,25 46:3,16 46:25 47:23 48:1 48:22,24 51:10 51:16 52:5 54:16 54:19,22 56:4,6 56:11,23,24 57:7 58:17 59:21 60:3 60:8,13,18 61:14 62:18,24 63:13 63:15 65:5,12 67:13 70:8,14,17 70:21 71:3,4,8 72:2,23,24,25 74:23 75:1,16 76:6 77:5,10,14 77:15 80:5 83:11 84:6,12,13 85:24 86:1 88:21 93:7 93:18 94:8,8 100:6 101:8,11 101:17,20,24 102:7 104:9 109:19 112:19,20 114:5,18 115:9 118:20 120:9 125:6 128:17 130:13 131:3 135:18 140:10 141:5 143:10,15 143:25 144:2 146:18 150:10 151:6 152:6,17 152:19 154:2,4 154:13 157:6,17 157:21 158:2,7 158:10 166:5,10 169:11 171:4,11 171:12,19,23 172:1,4,6 173:17 174:13 175:11,14 175:17,24
deteriorate 17:13 51:25 68:22 71:20 85:21 143:20 157:20
deteriorated 73:1 102:1 105:7 112:20 150:9 151:4
deteriorating 51:25 52:1 54:16 72:4 95:6 104:19 105:2 155:17
deterioration 12:19 44:19 48:23 49:13 50:1 50:19 51:1,19 57:2 59:7 60:9 66:1 73:8 81:1 83:4 86:14 87:25 93:13 105:17 106:3,19 107:10 107:11,14 108:22 108:24 109:19 116:21 151:7 165:6 166:10 169:8,22 174:4
develop 62:20
developed 22:7 34:15 60:11 70:12 72:8 139:19
development 3:23 4:2,5 148:1
devising 148:20
devoid 165:17
diagnose 119:9
diagnosed 141:4
diagnosis 143:13 144:16
diagnostic 41:15
dictated 136:18
die 110:11
died 4:19,21,23
dies 97:6 98:16,16
difference 76:4 110:18,19 111:2
different 6:10 13:18 21:15 26:10 41:25 95:13 110:23 124:22 168:2
difficult 9:23 30:15 32:11,14 33:7 55:12 86:5 86:12 107:1 142:23 143:19 155:24 176:21 180:13
difficulties 118:24 119:10
difficulty 70:12
dint 55:22
direct 27:4 117:20 121:18
directed 101:13
directive 160:10
directly 4:8 21:12 117:14,23 118:7 120:14
directs 39:15
disagree 166:13
disaster 92:11
disbelief 112:7
discharged 152:22 153:2
disciplinary 123:9
disclaimer 97:7 98:7,20
disclose 112:2
disclosed 111:12
disclosure 21:18 27:13
disclosures 111:24
disconnect 49:8 70:3 78:18 168:12,18
discover 29:25
discovered 180:10
discuss 82:15 108:12
discussed 17:9 28:8 30:10 71:6 76:4 96:4 100:9 105:13 148:24 155:11 174:1
discussion 119:21
disdain 112:7 129:24
disease 55:14
disorder 41:2 42:6 134:21 153:25
disorientated 73:3
disposal 8:18
disproportionate 161:21 162:2 163:18
disrespect 43:9
disrespectfully 156:16
disruptive 155:15
dissociating 68:11
distract 107:13
distress 62:8 124:9 128:19 134:10,18 135:9 164:4 167:21 178:3
distressed 66:10 129:22
divergence 40:20 42:9
diversion 175:18
divert 175:17
diverted 156:12
diverting 156:5
doctor 1:23 8:7 23:2,6,8,10,14,20 26:7,7,7 44:17 50:7 56:4 61:13 90:1 111:13,14 113:8 116:15 117:22 131:11 158:24 160:9 172:14,15,23,23 173:17 177:14
doctor's 89:19 97:16
doctors 99:16 172:20 173:7
document 22:20 22:21 113:11,14 115:13 116:20 131:9,25
documentation 5:8 130:11,13 131:2,4,8,24 135:12 136:20,23

documented 108:8 138:23 170:11,13
documenting 40:14
documents 5:1,5,9 59:20,23 137:2
doing 24:9,9 26:8 29:18 30:17 37:14 43:18 47:20 79:10 112:9 123:25 129:19 148:11 157:4 173:12 174:7 180:8
domains 3:12
double 83:23
doubt 28:10 118:8 122:9 146:4 149:8
Dr 1:3,4,8,10 2:25 6:1,1,3 16:13 17:6 19:12 32:1 32:1 35:15 36:15 48:2 59:12 62:6 64:14,14 73:11 74:11 76:19,25 77:8,18,20 79:25 81:9,19 83:9,16 86:21 87:12 88:18,25 89:21 90:7,11,25 91:9 92:2,2,19 93:25 94:10 97:19,24 98:21 100:1,14 101:6,10,21 105:8,16 106:15 106:25 107:18 108:3,12,14 111:6,11 112:17 113:4,19 114:8 116:4,15 164:3 165:24 166:20 177:15 178:20 179:14 180:19 181:9
dramatically 176:23
drawing 156:14
drink 133:18
drive 172:13,16
driving 172:17
dropped 161:14
drug 11:5
drugs 154:10
DSO 26:22 158:5
DSO04 157:25
DSOs 5:2 6:23
dual 157:13 175:9
due 63:17 71:8 88:21 91:3 123:12 131:21 143:3 161:20 175:10
duplication 54:3
Duracell 120:12
duties 22:18 36:2 104:6
duty 23:11 81:3 98:8 117:25 121:23 123:3,21 123:24 124:21 125:6 139:20
DVLA 172:11
dynamic 77:2 147:24 170:1
dysfunctional 72:18

E

E 64:21 66:9 67:12 68:22 74:2 116:1 116:5,8 133:7,7 135:24 158:25 159:2 160:5 163:22 181:7
earlier 19:19 36:20 60:21 81:24 83:18,19 84:15 87:6 93:12 97:21 111:13 114:17 119:21 155:12
earliest 12:18 53:14 55:1 75:15 75:18 93:22
early 10:24 11:17 13:3 84:11 110:18 112:23 158:17
earth 109:24
easier 151:3
Eastwood 2:19
easy 33:14 122:2,2
eat 74:18
education 34:19 80:16 139:12 148:2
effect 45:20 55:19 76:18 91:4 96:9 110:21 112:12,15 116:6 133:11 143:11
effecting 91:25
effective 61:5 77:19
effectively 8:24 14:4 18:7 19:16 26:13 29:13 31:7 36:6 37:22 39:12 53:6 57:17 65:18 69:8,16 99:13 111:20 144:24 146:8,24 155:17 164:10 167:8 172:3 174:19,21 174:22,24 175:3
efficient 147:24
eight 59:16
either 21:20 51:14 67:19 74:21 76:9 77:22 78:23 81:19 83:4 102:25 104:15 114:11,14 115:22 116:10 121:1 144:5 160:22
elective 25:9
elements 83:21 139:20
else's 36:7
embodied 69:25 80:13
emergency 87:11
Emotional 142:7
emotions 112:3
emphasis 36:18
encourages 24:2
encouraging 76:9
ended 132:21
endorsing 92:1
enduring 40:21,24 41:9,21
enforced 88:3 93:20
engage 133:10,10 152:1,21
engaging 133:14 133:19 134:13
England 2:15 3:7 3:17
English 142:1,20 143:2
enquire 126:12
enquired 122:5,24 123:1
ensure 27:2 29:20 34:17 49:9 122:8 138:25 139:18 140:7 149:22 158:2 171:16
ensuring 22:13 46:11 109:18 145:19 174:25 176:5
entail 3:2
entering 141:5
enthusiastic 25:8
entire 72:17 171:21
entirely 74:2
entitled 15:13 158:1
entries 73:22 136:21
entry 103:16 109:3 111:5 116:5 131:9,11,25 132:22 133:1,3 133:21 135:19 141:5 159:9,13 160:4,11 161:2
environment 6:10 6:25 8:1,2 14:18 25:11 33:13 59:21 63:4,18,22 63:24 64:7 68:4 85:5,17 143:15 143:20 149:17 156:8 165:15 177:24 178:1,1 178:23 180:12
environments 2:8 2:22 3:4 63:16
episode 49:14 80:7
episodes 84:3 119:14
equally 42:5 110:22 138:21
equivalent 174:10
eradicate 33:8
escalate 99:23
escalating 178:6
escalation 169:13
escort 88:21
especially 35:24 88:14
essential 12:14 20:25 30:19 34:17 35:7 52:2 110:3 174:25
essentially 4:21 13:13 20:6 80:1 86:22 98:3 113:14 129:2 140:2 174:7 175:5 180:9
establish 147:24
established 48:6 55:4 69:9,17 79:18 138:11
et 18:6 86:4 93:20
evaluate 18:18
evaluation 64:10
evening 133:20
event 23:8 93:9 148:18
events 35:1,2 93:8 100:5 111:24 116:7
eventuating 13:11
everybody 1:8 25:13,14 157:2
evidence 1:19 5:18 5:22,25 6:1,1,2,3 9:20 10:1 12:10 13:16,25 15:7,12

15:22 16:14 17:6 20:6 21:7,16 27:8,12 28:17,21 29:9,11 33:8,20 35:16 36:15 38:17,19,21 39:7 40:8,18 44:7 48:2 57:22 59:12 62:6 63:3,7,11,12 66:8,19 67:20 68:21 69:1,3 70:15 75:23 76:12,20,25 77:8 77:17,18,20 81:9 81:17 86:21 88:25 89:25 92:19 117:17,18 117:22 123:7,20 125:5 145:12 148:7 150:11 153:3 158:5 163:1 164:19,23 165:24 166:3 167:16 177:15 180:21
evidenced 161:17
evolves 149:11,12
exacerbate 165:3
exacerbates 165:20
exacerbation 64:12,12
exactly 68:10,25 74:7 95:15 103:10 106:6 171:21
examination 1:5 10:17 12:8 13:2 14:8 15:1 18:16 19:6,13 39:8 69:10 133:6 135:22 181:11
example 3:6 11:1,4 21:18 22:1 33:6 33:24 41:8 43:14 48:21 51:1 58:25 68:14 72:14 73:22 75:11 77:11 82:18 86:22 87:2 124:23 137:11 142:11 166:25
examples 2:13 10:25
exceptional 7:16 20:18 27:9
excessive 100:2,11 163:17
excessively 164:22
execute 149:21
execution 149:6
exercise 12:11 14:10
exercised 6:15
existing 64:2
exists 91:12
expect 8:16 24:24 25:4,6 135:7 138:22 145:24 163:6 170:12
expected 29:15 42:20 99:5 129:4 146:7
experience 4:6 20:12 25:6 64:4 74:20 77:4,9 110:15 142:2 143:3 144:25 157:1 172:1 179:15 180:1
experiences 111:3
experiencing 62:7
expert 1:12 4:14 33:11 38:23,23 39:3 62:13,14 74:17 98:23 100:3 161:18
expert's 73:6
expertise 155:6 172:15
experts 4:4 18:25 26:5,6 38:24
explain 16:2 29:21 29:24
explained 15:23 16:7 110:8 163:9
explains 15:19 30:7
explanation 58:13 59:15 79:2 93:12
explicitly 74:11
exploitation 154:13
exploration 9:22
explore 14:16 47:17 167:6
exploring 167:19
expose 25:11
exposed 19:10 21:13 37:5 100:10 126:3 146:16 171:25 172:3
exposes 44:18
exposure 13:14 24:22
expressed 104:24 159:12
expressing 144:19
expressly 97:18
extant 34:20
extended 166:16 169:6
extent 118:23 125:5 131:24 142:6
extra 17:24
extreme 56:14 62:8
extremely 134:24
eye 64:9

F

face 9:23 124:7,15
facilitate 87:3 88:23 90:10,19
facility 73:17
fact 2:10 3:13 24:3 32:12,18 38:11 45:21 46:8 51:24 55:22 60:13 67:18 73:16 75:21 85:4 87:23 90:6,8 100:17 114:9 132:15 134:10 146:10 156:1 169:17
factor 64:6 99:18 106:11
factored 105:18
factors 12:23 20:16 40:2,6 46:2 48:8 83:22 93:25 115:10,16 165:3,13 175:23
fail 69:9
failed 53:23 73:2 152:25
failing 37:18 53:18 69:12,18,22 81:8 109:21
failings 118:4 147:9
fails 132:25
failure 21:12 23:25 24:2 38:5 38:6 39:14 44:13 46:5 53:13 54:10 58:2 84:8 92:15 105:16 119:6,9 119:12 120:22 137:8 141:17 143:21 145:2,6 145:14 177:16,24
failures 54:13 100:6 105:10 112:17 117:3,7 156:7 163:12 177:20 178:17
fair 25:6 75:20 99:17 149:4 157:11
fairly 31:1 44:9 78:2
fall 156:19
familiar 35:9 82:23
famous 98:16
far 15:18 18:2 21:6 31:5 92:15 93:15 120:2,2 138:22
fashion 155:7
fast 61:25
fathom 79:3
fatigue 33:6
features 41:16
fed 129:25
feedback 42:16 44:1,11,11 48:7 149:9
feeds 175:25
feel 28:9 37:7 64:8 165:22 180:12
feeling 110:7 144:6
feelings 110:8
feels 16:25 67:4 105:23 119:20,22 134:15
feet 128:3
fell 155:18
felt 59:22 60:1,4 74:20 93:4 99:22 111:17 144:13 146:1 169:20
fill 79:11 130:14 130:19 131:4
filled 87:14 135:17 136:4
filling 44:22 48:11 136:23
finally 141:9 177:14
find 25:8 42:21 142:9 143:19 152:25 159:21
finite 67:7
fire 74:20
first 2:2,11,16 9:1 9:9,16,18 12:22 13:13 14:1 17:4 18:13 20:25 22:15 24:5,12,16 29:7 48:5,16 54:14 72:21,24 89:5 120:8 164:10,11 166:6 171:20 175:17
firstly 23:14 49:23 93:11
fit 46:12 57:9,13 74:12 87:10,10 87:13 88:6,8,20 88:20
fitness 172:13,16
five 18:14 19:5

122:18 161:10
fix 126:12 180:17
fixed 126:18
flag 38:15 84:5 176:7
flagged 16:19
flashbacks 62:9 144:12
flawed 149:5,7
flick 26:16
flight 88:3 92:11
floor 127:10,12 129:11,21 132:20 159:10,21,22
fluent 142:1
fluently 142:20
fluid 28:5 69:20 159:10 161:16,21 162:7,16,21 166:24 167:2,6 167:14,24 168:14 168:22 170:3,10 170:16 174:2 177:6
fly 87:10 88:6,8,20
focus 10:22 27:15 27:25 38:17 65:22 142:8
focused 32:19 35:2 38:8
focusing 11:12
follow 23:25 51:19 108:16 174:5
follow-up 102:12 109:2,16 176:18
followed 29:20 102:17 108:21 166:15
following 11:15 15:21 23:24 103:20 104:6,12 106:8,15,25 115:24 116:19 139:1,1 169:9,15
food 28:5 69:20 115:13 116:21,24 159:9 161:16,20 162:7,16,20 166:24 167:2,6 167:14,23 168:14 168:22 169:6 170:2,9,16 174:2 177:6
footage 82:22 118:13 119:19 120:10 122:3,19 126:7,25 128:17 129:13,15 132:24 136:14,25
footnote 180:5
force 5:10 28:13 55:1 87:2 88:17 88:23 89:2,7,8,10 89:18,20 90:1,4,9 90:13,17,22 91:5 91:7 92:5 94:3 95:22,24 96:1,7 96:25 97:19,23 98:2,16,23,24 99:6,16 100:11 103:14 112:21 115:25 119:16,25 120:1 121:7 123:17 130:10,12 132:25 133:22 134:3 135:14 136:7,8 137:12 138:18 139:4,7 139:10,14 140:13 140:15,17 145:17 156:4 159:1 160:22 161:5,6,7 161:11,18,20 162:2,3,9 163:2,3 163:7,8,16 177:10,11 178:11
forced 92:11
forcibly 128:16
forefront 122:12
form 39:15 48:4 60:14 76:17 81:6 92:14 93:14 100:11 101:13 130:11,13,20 135:14 136:7 138:9,9 156:15 156:23 161:6,11 175:3
formally 37:11 66:17 177:1,5
formerly 5:16
forms 5:10 38:20 48:12 62:3 75:24
forwards 18:3 149:19
Fosu 4:15,19
found 73:2
foundation 48:16
foundations 148:11
founding 70:19 79:9 80:13
four 77:12 127:9 127:11 141:6 144:7,8
four-person 161:12
fourth 141:11 143:11
Francis 129:9,18 130:3
Freedom 5:20 25:20
frequently 62:2 99:23 140:19
fresh 111:13
frightened 134:21
front 1:18 10:14 55:18 115:1 175:21
frustrate 86:18
frustrated 85:23 118:16
frustration 145:22
fucking 97:16 121:15 127:21
fulfil 14:25 145:14
fulfilled 85:11
fulfilling 173:18
full 1:6,21 14:7 19:6 38:16 54:25 55:21 63:14 99:3 99:5 106:16 110:21 123:22 143:7 161:12,24
fully 26:9
function 75:1
functions 12:5
fundamental 76:4
fundamentally 149:5
further 8:21 9:21 11:14 12:18 14:16 21:15,20 52:10 62:19 71:20 75:8 84:1 86:8 94:23 102:17 105:7 108:11,12 116:24 117:8 118:19 122:5 126:4 138:3 146:17 157:12 159:17 169:12,15,21 170:18 179:10

G

G4S 22:20,23 23:22 105:14
gain 170:23
gap 156:20 157:14 157:19 158:8
gathered 20:22 176:1
general 3:11 31:4 64:18 117:6 127:10 159:25
generally 9:22 44:17 112:13 119:1 145:22 153:6 168:4 172:21
generation 144:22
gentleman 83:22 100:5
getting 85:23
give 1:6,12 2:13 10:25 24:14 63:5 64:8 79:20 95:8 96:10 97:10 130:5 158:2
given 10:16 12:14 17:19 35:11 39:23 43:20 45:19 47:6 68:14 69:3 76:8 79:12 85:22 88:14 91:21 94:11 100:23 102:21 110:7 113:23 122:22 123:1 136:7 138:4 142:16 145:14 148:20 150:4 154:24 162:18 170:2
gives 61:22,24 157:16
go 8:21 10:14 20:21 22:25 26:17 28:22 45:14,17 47:19 49:22 55:9 62:23 64:19 77:24 84:23 113:1 120:21 132:10 133:2 135:18 138:21 143:7 149:19 156:11
go-to 137:16
goes 7:25 32:16 68:2
going 12:18 14:16 18:3,8 19:18 27:1 29:22,23 37:10,13 43:6,23 54:1 68:4 88:13 92:7,9 95:14,19 96:24 97:23 98:19 104:8 109:25 112:24 121:14 122:11,15 123:4 124:4 125:3 130:14,15 131:4 140:3 155:20 167:1 175:19 178:13 180:15
good 6:4 8:22 35:11 47:14 75:11 77:11,25 154:20 155:2 158:18
GP 2:6 4:5 9:12 11:7,14 14:23 15:2,7,18,21

16:16 18:12 19:14 21:20,21 24:20,22 25:2,7 26:14 29:24 30:4 36:10 38:10 39:15 41:24 50:13,17 51:8 53:23 55:12 57:6 66:2 73:15 81:20 102:3,13,18,21 102:25 103:3 109:5,17 172:12 180:11
GP's 10:3 24:18 36:11 40:22 41:23 42:9 51:2 85:13 94:16
GPs 2:6 3:3 5:13 7:24 17:23 31:9 31:15,16 32:3 40:19 50:24 53:8 53:16,20 57:1 75:7 84:20 88:6 89:1 174:7
GPs' 2:22 84:15
grab 97:8
graft 83:24
grafting 84:22
grateful 151:17
great 126:14
ground 6:7 13:19 67:2
group 2:23 3:3,23 4:2 14:14 25:12 68:18 142:7
grow 178:23
guess 9:25 19:19 32:19 40:20 80:9 93:12 107:7 155:25 174:20
guidance 3:13 4:5 5:4 34:25 88:4,7 88:10 96:11 158:2
guided 44:11
guideline 3:22 4:2
guinea 154:9
guy 97:4

H

hair 109:24
hand 86:7 107:1 160:18,20
handcuffed 161:9
handcuffs 160:25 161:23
handed 2:24
handing 111:19
handover 138:23
hands 121:10 125:17 129:25 133:15 136:2
hanging 73:3
happen 29:1 40:24 62:9 92:12 112:6 115:6 138:1,24 140:19 175:24
happened 38:13 83:18 96:23 106:20 115:3 137:10 142:10
happening 6:7 10:3 19:16 67:1 67:19,20 69:1 72:1 79:16,17 122:5,21,24 123:2 127:12 138:5 145:3,23 145:24 146:3,5 156:22,23 170:15
happens 97:14 175:18,24
happy 88:22 90:1 94:5
hard 1:3,4,8,10,18 61:25 113:4 129:18 179:14 180:19 181:9
harm 7:12 8:19 12:23 13:11,14 14:20 18:10,11 20:5,17 21:13,13 37:5 41:22 44:19 45:13 54:22 55:3 55:5,7,8,11,19,20 56:4,7,11,15 57:11,15 59:1 73:7 75:21 85:10 85:11,15 117:23 118:7 143:17 146:16,17 147:16 151:22 157:19 166:18,19 171:25 179:1
harm's 98:21
harmed 6:24 8:10 71:4 72:2
harmful 64:1 68:5 68:8,10 141:24 145:15
Harmondsworth 4:15,20
head 16:13 76:19 81:20 129:25 145:25 146:2,4
health 3:10,23 9:3 9:7 10:23 11:4,8 11:18,24 12:21 14:12 16:4 17:16 21:4 36:13,13 38:6,7 39:10,12 39:21,22 40:1,15 40:20,22,24 41:21 42:1 43:16 48:24 49:14 51:2 56:20 57:5 60:2 63:3,18 66:1 68:15 73:1 77:13 82:7 84:2,16,18 85:1,8 86:7 87:16 91:15 94:9 94:13,16 95:16 100:16,20 104:19 105:2,7,16 106:21 108:10 112:13 118:14 119:9 134:14 135:10 141:13 142:7 144:1 147:17 152:12,19 152:23 153:2,16 162:23 164:5 165:3,6 167:1 169:9 174:3 176:8 178:2,4,6
healthcare 5:14,19 6:5 7:9,10,21 8:8 8:17 16:2,14 20:2 22:13,17 24:8 29:9 33:25 34:9,17 36:8 39:25 49:9,18 53:13,16 65:9 66:8 73:21 76:8 76:16,20 80:17 80:20,25 81:21 86:18,19 87:9 88:25 93:4 96:19 99:15 104:25 110:2 111:15,24 118:20 120:5 123:17 131:1 138:25 139:13,16 140:5,8,21 144:3 144:5,9 145:11 146:1,3,5,7,13 147:2,3,5 148:10 149:11 152:2,9 152:21 154:5,12 154:17,21,24 155:9,18,20 156:2,22,24 157:4,10 162:4 164:18 166:20 169:20 173:8 174:6 176:8 179:7,21,22 180:6
hear 109:22 118:20 123:15 124:3,21,24 125:7,17 126:25 128:17 129:14 132:14 180:20,25
heard 13:16,25 15:7 18:12,19,23 25:20 45:7 53:24 63:3 70:10,15 71:25 75:23 78:11 81:17 91:9 91:18 120:13 121:14 122:3,17 122:18,20 123:7 126:21 127:6,16 128:9 158:25 164:19 167:5
hearing 127:3 181:3
heart 55:14 87:24
help 26:6 34:2 47:18 68:13 139:18 142:5,6 142:19
helpful 97:2 142:9 171:10
hesitate 176:24
high 3:5 30:15 57:23,25 58:1 61:17 66:16 78:9 78:13 81:5 99:2 165:22
high-risk 93:6
highlight 10:23 11:8,13 93:21
highlighted 49:7 176:14
highlights 169:25
highly 128:21
his/her 23:7
historically 24:5
histories 84:19
history 30:2 32:20 38:25 39:6,23 44:18,23 62:2 74:10 88:15 92:10,21 93:17 94:10 99:20 113:21 114:3,20 141:15,22 174:2
HMP 2:20 25:10 113:12
HMPPS 3:7
hoc 31:1 43:6,18 43:22
hold 2:2,21 121:11 123:18 126:22 132:3 134:4 148:4 161:9,9
holder 18:21
holding 3:1 160:18 160:19
HOM002581 26:12
home 6:16 7:13,15 7:19 8:6,9,18 13:1 26:1,18

27:4,7 32:17,25 37:3,6 39:24 41:11 42:12,18 42:19 43:10,21 45:4,15 46:2 47:2,11,16,21 50:21 51:14,20 52:4 53:4 54:11 54:14 56:5 57:11 58:23 70:11,14 73:4 74:17 75:9 75:14,25 76:3,5,9 76:14,21 77:2,5,7 79:14 81:17,22 81:23 82:9 83:2 83:10 84:11 87:14 88:18 101:15,18 102:6 103:4 104:7 105:3,13,17 106:2,10 113:21 115:8,17 116:23 146:18,23 155:8 157:25 166:8 169:10,14,18,21 170:4,23 171:3 171:10 172:7,19 172:23 173:21 174:11,15,23 175:13,20
homes 84:21
homework 175:8
hope 62:19 64:24 110:7
hoped 154:21
hopefully 140:19 166:12
hopeless 72:5
hospital 73:14,20 86:3,10 87:11
hospitalised 154:1
hours 9:10,13 10:8 10:19 11:7 14:2 15:9 16:17 18:13 19:1 23:9,14,20 29:23 115:4 176:23
House 4:10 5:8,14 6:8 11:21 20:7 28:19 31:9 32:2 33:21 34:22 63:4 63:10,15 67:17 72:25 73:10,12 74:12,15 81:20 83:25 84:4 103:18,25 104:4 105:14 113:10,18 137:14 139:21 141:11 142:6,12 143:12,16 144:8 144:24 154:15 158:11 167:7 179:20
huge 41:25
human 48:14
humble 39:3
hurdles 155:5

I

idea 99:20
ideally 139:13
ideation 64:3 65:17 66:11 79:24 104:25 113:22 114:4 119:13 141:16 144:7,11,19,23 163:25
identifiable 56:3
identification 11:18,24 24:17 44:2
identified 21:15,17 37:21 42:15 46:8 46:12,15 47:7 51:13 71:22 117:12 118:24 142:12,15 144:6 152:18 158:8,12
identify 6:23 7:12 12:6,15,22 16:4 17:10 22:17 34:11 38:5,6 43:14 48:8 56:1 57:10,15 80:24 141:21 142:21 151:3
identifying 12:20 14:13 37:17 152:10,12
idiot 120:12
ill 99:14
ill-health 61:13,14 63:17 65:11,17 164:1
ill-treated 163:14
ill-treatment 62:3 74:25 99:14 100:10 118:25 119:10 140:10 146:25 147:11,15
illness 41:9,9 64:16 66:18 86:22 100:8
illustrate 117:7
illustration 117:3 163:24
imagine 18:17 36:11 135:1 149:12 175:20
IMB 139:3
immediate 11:1,8 23:10 81:14 90:10 137:19
immediately 17:10 56:7 90:23 116:14 121:11,15 121:25 130:19
immigration 3:4 4:6,8 6:5,18,20 7:3,9 8:3 9:2,4 25:2 26:9 30:13 36:11 61:16 93:18 94:19 107:11 115:10 141:5 143:10 157:7,23 158:1 164:21 176:9
impact 32:10,21 39:15 43:17 44:13 46:17,24 51:10 68:7 85:4 88:14 94:8 95:18 101:8,11,20 102:7 110:1 111:23 118:4 150:10 151:6 172:16 178:2
imperative 75:14
implication 143:6
implications 18:6 20:1 26:10
importance 16:3 70:22
important 7:11 8:6 11:17,24 12:3,9 13:8 16:6 40:14 43:3 52:1 52:2 80:24 81:2 89:1,16 96:5 107:13 108:20 123:16,18 124:6 124:12 146:1 152:8 153:7 173:7 180:20
importantly 54:18
impossible 20:7 31:6 143:1 177:18
impression 76:8
improved 34:19
improvement 3:7 46:10
impunity 140:2
in-bed 179:22,24
inability 85:24 122:11 127:18
inaction 118:9
inactions 126:3
inadequate 23:22 23:25 24:1 29:9 31:10,13,23 39:5 44:3 47:7 54:9 69:4 100:24 145:13 146:11 147:7
inadequately 38:1
inappropriate 17:8 89:23,24 120:9 121:2 164:4 178:5,14
inattention 75:12 145:21
incapable 60:7
incident 92:18 99:1,12 103:20 104:2,18 110:4 110:15 112:18 116:2,14,19 117:10 120:3,6 121:6 126:23 130:9 132:10 133:4 134:7,16 134:22 135:15 136:9,14 137:2,3 137:12 138:1 139:1 161:19 163:20
incidents 50:25 70:11 73:5 104:24 112:4 117:2 139:4 165:19 178:18,18
include 11:1
includes 89:1
including 3:20 5:2 5:3 28:13 66:10 104:25 117:18 119:12 158:11 159:2 161:13 165:7
incontinent 159:20
incorrectly 98:18
increased 64:12 165:13 178:6
increasing 72:5
independence 172:21
independent 1:11 4:14 27:8 73:6 74:17 154:6,17 154:23 155:21 157:3 158:9 170:22 171:2 172:7,20 173:20 174:14 175:10,12
indeterminate 45:7
indeterminately 45:6
indicate 20:16 73:18 75:25 105:10 111:6 141:17 142:22 143:21 144:1 160:11

indicated 23:12 28:8 46:18 57:25 58:1,10,15 81:5 81:24 114:4 162:15
indicates 53:7 119:8 145:5 160:22
indicating 78:13 103:16
indication 61:24
indications 91:6
indicative 141:21
indicator 41:22
indicators 55:25 84:5
indirect 117:21 118:1,6
individual 11:18 43:4,4 48:11 68:11 72:20 88:14 111:21 117:23 141:24 153:4
individuals 48:11 69:22
induced 86:1
induction 28:18,21 29:4 35:8 141:13
inefficiency 148:18
inefficient 147:22
inevitable 143:14
inevitably 142:8
infarctions 92:22
infinite 81:12
inflexible 148:18
inform 8:18 70:10
informally 43:6 66:17
information 20:22 32:17 33:1 43:11 43:13,24 45:16 45:20,21 47:21 49:8 51:20 52:4 75:14 76:14 79:12 87:22 91:1 91:10,11,13,14 91:16 96:6,15 98:9 101:22 103:8 106:11 109:4 148:15 155:11 162:18 169:21 171:11 173:3,4,5,23 174:16 175:21,22 176:1
informed 16:10 144:5
informing 8:8 77:2
inherently 11:17
initial 19:14 20:15 51:19
initially 16:20 53:18
injuries 38:25
injuriously 114:5
injury 135:16 136:10
inpatient 73:17 154:1
input 66:2 67:14 170:23
INQ000075 1:17
INQ000112 1:17
inquest 4:14
inquiry 1:6,11,12 4:11 5:1 35:1 66:9 74:16 111:9 116:24 117:19
inquiry's 98:23 161:18
inside 41:24 74:18 176:8
insight 143:2
instruct 152:17
instructed 1:12 4:13
instruction 99:8 135:21
integrated 155:7 155:12
intend 1:23
intended 28:3
intending 127:21
intensely 95:15
intention 102:2 125:2
intentional 86:17 138:8 162:19
intentions 49:4 144:11
interact 28:10,11 28:25
interaction 28:4 111:11 174:9
interested 25:12 111:14 179:19
interesting 80:18 108:2
interests 90:13,16 90:21 105:25 106:1,12 160:5
intermittently 92:24
interpreters 143:5
intervene 89:11 121:23 127:13 130:4 137:23
intervened 122:4 123:10 127:15 128:12,24 129:17
intervening 122:12 130:2
intervention 65:10 66:5,25 71:9 79:20 99:4 165:25 178:13
interventions 65:16 138:13,19
intoxicated 66:21
introduced 157:25
introduction 158:5
inverted 161:8
investigated 167:18
investigation 4:18 153:18
investigations 3:19
involve 4:1 139:15
involved 4:2 9:17 26:19 65:9 104:17 116:14 180:8
involvement 67:15 138:3 173:15
involving 57:24
Iraq 141:3
IRC 4:15,20,21 6:13 8:7 9:8 16:17 41:18 43:7 63:21 103:12,21 154:16 173:18,24 174:16 179:18
IRC's 41:4
IRCs 6:10 25:24 154:19 165:8
isolating 144:12 165:15
isolation 165:2,12
issue 36:3 37:2 41:12 55:17 63:21 75:9 80:9 88:2 91:13 97:21 107:8,13 117:19 119:20
issues 4:17 10:23 11:8 21:4 30:5 33:10 42:1 49:22 54:8,11 61:23 64:13 68:15 75:3 82:8 84:2,19 87:8,17 91:8 100:16,20 143:19 148:21 167:1 169:15 171:4 174:3 177:19
IV 98:17

J

Jake 1:9
James 1:4,8 181:9
Jesse 1:4,8 181:9
Jo 120:7 121:9 126:21 128:2 129:8,13 130:10 131:9,24 133:3 135:24 163:21
job 2:11
jobs 157:5
Jon 98:23
journey 29:1
July 82:19 83:9,16 92:20 100:15 141:7 157:25
June 141:7
Justice 5:20 158:4 158:10
Justice's 20:12 77:9
justification 163:8
justified 99:3

K

Karen 63:4 108:10
Katona 62:16
keep 33:16 80:1 173:15
keeping 80:4
KENCOV1007 126:7
kept 177:23
key 34:23 40:1 43:8 51:12 172:9
kick 166:8 176:3
kind 106:6 155:7 179:21
knees 161:15
knew 51:14 93:16 95:4
Knobby 97:8
know 18:25 22:12 24:8 27:23 30:3 30:12 31:7 35:1 35:19,24 36:9 37:7 38:24 40:25 41:3 42:1,24 43:20 47:15,24 48:13,16 51:21 51:22 52:5 55:13 70:15,18 73:5 75:6 77:16 78:8 79:25 80:19,21 80:22 81:3,25 82:2,4,6,7 84:17 85:19 86:5,5,9 88:15 91:11 92:11,17 95:6,16 96:17 100:1,3 101:5 106:16,19 107:2,4,6 108:12 109:22,24 112:1 112:7,8 113:9 116:1 124:12 125:1 128:22 132:11 134:20 138:3 139:3

145:4,21 146:1 149:11,12,16,18 154:9,22 161:5 161:10 162:17 164:11,14,21 172:20,22 173:24 175:1 176:10,12 176:23,24 178:25 179:5
knowing 86:8 93:17 140:3
knowledge 143:2
known 1:8 3:8 41:12 49:8 87:16 90:3 93:25 178:2
Kwabena 4:19

L

lack 25:17 29:13 31:3,5 48:3 53:8 57:22 59:13 61:1 63:18 73:23,24 76:22 81:4 99:9 102:12 112:5 139:23 141:21 143:10,14 144:1 145:21 146:23 151:19,23 152:13 152:20 157:8,16 158:3,6,12 162:20
lacked 152:16 157:21
lacking 119:5
ladies' 2:19
large 5:1,12
largely 69:13
late 93:15,22 101:1 129:1
lawyers 154:6
lay 98:3
layers 117:21
lead 11:3 12:18 38:20 47:12 69:17,20 77:4,10 81:20 87:24 93:8 93:19 118:5 143:17 146:25 160:3,12
leading 12:23 21:19 22:2 36:21 49:19 100:20 168:15 174:7,8
leads 16:24 20:5 37:16 178:5
learn 34:25,25 149:16
learning 35:3,4
leave 23:1 70:25 120:21
leaving 74:23 87:15 103:19 104:5 134:3
led 26:2 54:10 92:17 112:19 119:16 147:11 163:13
ledger 18:21
left 39:12 50:7 62:18 71:3 128:4 138:20
legal 48:14 154:18
Leicester 2:16
length 18:23 132:10 143:15
lengthy 112:25 167:1
let's 24:15 40:25
letter 87:14 88:18 90:8,25 91:6 94:1 97:17
level 3:5,21 14:23 28:2,22 30:7 33:18 40:9,25 46:19 53:18,23 80:11 82:7,8 99:2 115:10 124:9 129:20 134:17 165:22 176:16 180:3
levels 18:18 61:18 135:9
liaison 175:18
liberty 179:6
licence 172:18
lie 19:20
life 81:15 90:9,23 110:7 111:25 137:23 149:11
life-saving 137:19
life-threatening 99:13 145:8
ligature 74:3 103:12 104:2 110:5 115:25 133:9 134:1 135:25 137:22,24 137:25
light 87:11 145:4
likelihood 55:8,11 85:11,15 111:23
Likewise 121:14
limb 27:11 49:2 81:15
limbs 26:21 27:19 27:24 28:1,11 48:18 49:20 50:12 52:16,20 54:1 77:25 114:15 115:22 148:25 151:15 176:6 177:7
limit 6:18 179:4,5
limited 30:25,25 71:9 143:1,2,2 147:15
limits 143:10
line 1:24 34:24 120:19,20 130:22 130:23 131:6 174:10
lines 97:3
link 56:25 80:24 84:25 99:13 119:8 177:2,5,15 178:17
linked 62:2 79:5 118:8
list 84:23 85:2
listened 36:15 44:7 148:6
literature 45:10
little 13:23 17:1 37:7 39:20 58:24 67:14 70:4 84:14 119:21 122:16 162:1 179:16
Little's 160:4
live 5:18,22,24 117:18
lived 33:12
living 80:22
located 164:25
lock 161:9
logic 67:3
logo 26:18
London 2:5
long 8:13 17:25 18:14,14 24:21 88:9 180:20
long-term 36:13
longer 138:2
look 8:25 9:1 10:12 13:22 22:20,25 23:2 24:11 26:12 35:14 37:20 38:25 54:24 61:13 65:15,24 72:20,21 78:7 79:15 82:14 96:23 97:2 101:3 107:23,24 108:5 109:3 113:8 126:6 130:5 131:8,9 133:1 135:12 156:16 158:24 159:6
looked 5:7 12:5 18:3 22:11 26:15 39:18 41:24 44:15 55:4 56:18 58:20 66:20 72:15 113:9 148:7 161:19
looking 42:8 55:8 82:17 88:3,7,13 96:10,21 100:4 140:13
lose 30:16,19
loss 62:19
lost 24:5 72:9 110:7
lot 19:10 172:24 179:15
lots 35:22
Loughton 97:9
love 47:16
low 35:23 40:25 161:17
low-level 40:25
lying 129:21

M

magnetised 156:13
main 68:14
maintain 46:3 101:17
maintained 43:20 77:15 115:9 169:11
maintaining 27:5 40:2 47:25
majority 37:25 38:13
making 12:11 19:19 51:15 75:7 82:20 96:4,5 106:5 115:14 126:22,24,25 128:9,18,22 162:9
Makucka 135:20
man 4:19 99:14
manage 42:3,10 56:23 57:6 59:23 60:17 65:19 66:9 66:17 71:7 80:12 84:18,20 85:1,2,7 85:14 86:6 94:17 96:9,12,17 119:9 156:8 178:10
managed 44:9 45:1,22 59:21 60:3 64:21 67:13 74:2 78:11 159:15 163:21 169:7
management 11:5 59:18 60:13 65:14,25 66:4,24 67:3 71:14,16,16 79:19 120:19,20 130:23,23 131:6 145:11,13 146:2 146:6,11,22 174:10

managing 57:17 60:8 61:13 163:25 164:4
manner 38:23 119:18 129:3 145:20
map 38:18 136:4
marathon 95:12
March 1:1 2:24 72:23 73:9,11,11 73:20,23 74:3,11 77:14 181:4
Mariola 135:20
marker 175:8
massive 110:1
material 10:1 53:7 58:9 79:15 110:3 119:2 169:8
matter 4:4 18:25 26:5 30:14 41:14 55:19 96:18 97:5 123:11
matters 1:13
mean 7:23 8:9 11:11 14:11 18:19 44:21 45:3 61:20 74:7 86:2 99:17 117:22 132:9,17 139:25 140:18 149:4 154:20 156:15 172:9 173:3,19 176:21 178:20
meaning 76:16 112:20 161:25 171:19
means 1:23 12:9 17:13 21:12 36:6 117:20 118:1 140:13 164:4 176:13 177:22
meant 54:4 75:1 75:16 160:18
measure 166:9
measures 18:4 149:15
mechanism 9:19 34:13 36:19 37:14 46:9 47:2 48:7 51:7 58:23 75:15 77:19 109:15 110:2 144:22 145:19 147:6 175:12,16
mechanisms 21:3 22:14 54:2 61:2 69:23 82:9 99:24 109:12 164:15 175:2 176:3
medical 1:12 5:9 5:20 10:17,18 15:2 18:16 20:12 24:18,23 25:7 49:3,10 50:16 73:6 77:9 88:21 88:22 91:1,12 92:3 93:6,17 96:10 103:16,22 116:18 133:1 138:20 141:14,22 142:16 152:4,16 153:5 157:22 158:4,10 159:6 170:22 171:2,3 172:7,12,16,19 173:20 174:14,22 175:10
medically 26:2 43:10
medication 11:3,5 82:21 104:22 106:23,24 108:23 109:1
medications 84:23 85:2
Medicine 2:4
meet 50:4 88:4 136:22
member 114:25 140:1
members 49:18 53:15 145:24
membership 2:5 3:3
mental 10:17 14:7 14:12 19:6,13 36:12 38:5,7 39:10,12,21,21 40:1,15,20,21,24 41:9,21 42:1 43:15 49:14 51:1 56:20 57:4 61:14 63:3,17,18 64:16 65:11,17 66:1,18 68:15 72:9 73:1 77:12 82:7 84:2 86:22 91:2 92:4 100:8,16,20 104:19 105:2,7 105:16 106:21 108:9 112:13 118:14 119:9 134:14 135:10 144:1 147:17 151:17 152:19,22 153:2,8,16 154:4 158:1,6 162:10 162:11,23 164:1 164:5 165:3,6 166:25 169:9 174:3 178:2,4,6
mentally 4:23 68:22 128:20 134:10 144:14
mention 24:14 33:5 39:9,18 132:25 133:21 141:15 143:9 144:1
mentioned 28:10 29:2 43:15 78:24 100:14 152:15 171:4 172:10
met 57:3 58:16 101:16 111:22 112:7
middle 23:1
mightn't 143:4
military 142:2
mind 18:20 37:8 41:23 42:9 57:1 93:19 99:18 105:20 106:7 108:25 122:13 127:4 130:1 135:2 155:3 180:9
minimal 133:11
minimised 56:9
minor 40:25 41:14
minutes 18:14,14 18:19 19:1,5,11 126:11,13 127:23 129:6 158:19 161:10
minutes' 18:22
misaligned 17:1
mischaracterised 86:23
misdirection 76:11
misplaced 36:18
missed 11:3 102:16 106:15 108:13 109:18 152:21 153:15,18
misses 135:6
missing 12:12 48:3 48:17 84:25 92:25 102:13
mistaken 150:12
mistreatment 117:15 126:4 177:17 178:19
misuse 3:12
misusing 98:9
mitigating 87:17
Mmm 110:12 135:5
Mmm-hmm 96:3
mobile 131:18 133:11
moment 10:6 19:21 32:2 39:21 45:7 112:24 116:3 122:17 155:25 175:5
Monday 1:1
monitor 89:10 124:7,9 125:9
monitored 109:20
monitoring 89:2 123:16 124:1,16 124:16 140:23
month 93:24
months 104:20 158:11
morning 97:8 117:14 152:15 171:5
motivation 62:19
mouth 127:20 131:19 133:12
move 48:18 99:8 111:19 116:8 129:5 141:2 151:17 160:16
moved 116:1 160:5
moving 121:6 170:18
multiple 84:5 104:24 117:21
murder 3:20
mustn't 64:23
myocardial 92:21

N

N 181:7
name 1:6,8
naturally 99:21
nature 7:2 63:17 88:22 94:12 132:1,23 134:6,9 137:3 148:18
necessarily 20:23 24:24 26:2 37:9 38:20 42:11 56:22 82:4 88:12 91:15,16 95:5,9 96:12 107:9 108:6 112:2,9 175:20
necessary 28:23 46:11 99:6 103:3 158:2 166:12
neck 82:20 103:13 121:10 122:18,21 124:7,16 131:18 133:9,15,17 134:1 135:25 136:2,3,5,11 137:22
need 8:21 11:8 12:6 19:23 21:4 23:15 24:15,16 26:4 27:24,24

29:21,24 33:16 34:24 36:5 42:4 45:17 47:20,21 50:11 51:22 56:7 68:16 70:7 79:11 79:14 85:5 88:21 96:13,15,18 110:19,23 114:14 125:2 130:19 137:22 138:24 143:5 149:18 153:16 158:9 163:8 166:4 174:22 175:23 176:11,17 180:3
needed 54:2 74:14 91:25 93:13 109:12,12 155:6 165:24 168:24 179:18
needs 9:21 11:18 11:24 12:21 14:14,16 16:4,5 18:3 21:9 34:3 34:12 35:25 36:4 44:2 61:4 64:19 65:21 68:5 70:1 93:19 139:11 148:20 152:10 155:6 156:9,22 172:17
negative 40:2 46:17 112:15,16 115:10 178:2
neglect 162:16
neither 98:13 117:24 137:1
nervous 99:22
net 155:18 176:14
never 4:8 61:20 76:20 81:9 142:10
nevertheless 73:8 169:22
new 2:25 34:15,21 35:7 148:1
NHS 3:7,17
NICE 3:22 4:3
night 35:25
nine 114:7,18
NMC 123:9
nods 168:13
noise 126:23,25
noises 127:17 128:8,18,23
non-attendance 108:20
non-compliant 86:24 87:4
non-medical 91:3 98:4
non-negotiable 130:25
non-use 81:22
normal 8:2 109:5 128:21 132:18,18 132:19
normalisation 80:10
normally 27:8
notably 83:11
note 104:12 105:1 111:4 136:13 160:8
noted 82:19 101:25 133:17 136:3 150:3 159:23 160:7
notes 159:13
notification 7:19 37:11 54:10 106:18
notified 13:1 54:15 85:9 146:17
notify 7:13 50:21 75:8 83:2 104:6 169:14
notifying 8:6 56:5 58:23 102:6 103:4 106:9 113:21 166:8
notion 156:11
notwithstanding 143:13
November 141:9 143:24
nuisance 112:8
number 5:1,12 7:4 13:17 18:25 19:22 22:10 30:15 47:8 57:24 58:4,6 60:23 71:2 92:8 98:5 132:9
numbers 42:23 66:16 78:9 139:6
nurse 9:9 22:1 23:5,11,14,15 26:7 30:1 63:3 108:10 116:14 117:23 120:7 126:21 128:2 129:8,13 135:8 135:20,20 136:22 159:11,24 160:12 163:6 180:13
nurse's 161:4
nurses 17:23 111:19
nurses' 21:16
nursing 11:12 13:25 14:7,23,25 15:17

O

obligation 8:13 22:16,17 124:2
obligations 31:12 145:14 146:11
obs 133:16
observation 57:25 96:19 116:2 132:21
observations 131:20 133:16 135:6 159:17 167:7,9,13
observed 116:20 160:6 164:19
obstruction 124:8
obtain 91:19
obtained 154:6
obtaining 43:4 142:2
obviate 114:14
obvious 79:15,16 128:20 129:15
obviously 17:2,25 18:5 27:22 58:5 60:23 100:2 179:15
occasion 73:4 83:5 83:13 113:20,25 141:12,15 143:12 153:9
occasionally 69:14 70:16
occasions 39:14 68:12 86:3 122:19 141:7 142:5 144:7,8 152:23
occur 89:11
occurred 14:4 52:20 114:17
occurring 66:19
occurs 9:3 40:7
October 26:14 141:8
offending 99:20
offer 99:2
offered 37:2 107:5 142:7 143:14 158:3
Office 6:16 7:13 7:15,19 8:6,9,18 13:1 26:1,18 27:4,7 32:17 37:3 39:24 41:11 42:12,18,19 43:10 45:4 46:2 47:2,11,21 50:21 51:14,20 52:4 53:4 54:11,14 56:5 57:11 58:23 70:11,14 73:4 75:9,14,25 76:3,5 76:9,14,21 77:2,5 77:7 79:14 81:17 81:22,23 82:9 83:2,10 84:11 87:14 88:18 101:18 102:6 103:4 104:7 105:3,13,17 106:2,10 113:21 115:8,17 116:23 146:18,23 155:8 157:25 166:8 169:10,14,18,21 170:4,23 171:3 171:10 172:7,19 172:23 173:21 174:11,15,23 175:13,20
Office's 32:25 37:6 43:21 45:15 47:16 101:15
officer 159:21
officers 80:23 87:23 125:1 140:6 152:18
okay 19:3 176:1
Ombudsman 3:10
ombudsmen 3:14 3:14,18
omission 28:5 100:23
once 67:16 85:21 96:14 137:24,25 172:6 173:16
one's 93:19
one-off 8:12
one-sided 78:3
ongoing 3:21 11:18 30:17 32:10,23 46:16 48:24 61:1 94:12 101:8 102:7 109:19 116:21 140:17 156:3 169:1 174:12 176:18
Oozeerally 16:13 19:12 32:1 35:15 59:12 76:19,25 81:9,19 83:16 88:18 89:21 90:7 90:11,25 92:2,19 93:25 94:10 97:24 100:14 101:6,10,21 105:8 106:15,25 107:18 108:3,12 108:14 111:6,11 114:8 116:4,15

Oozeerally's 6:1 36:15 77:18 97:19 98:21 105:16 112:17
open 57:24 78:22 169:19
opened 58:5 73:10 78:10 82:25 103:17
opening 111:7
opens 137:9
operate 6:10
operated 146:24
operating 13:9,19 16:23 70:3 146:8 149:22 176:5
operation 88:9
opinion 1:13 39:4 53:7 99:1 101:7 101:11 117:11 169:7
opportunity 12:22 13:13 14:1 22:15 53:14,22 55:1 56:6 75:15,18,19 93:22 139:15
opposed 43:3 48:11 151:6
opposite 90:7
option 125:14 137:16
optional 78:5
options 71:14,19 119:24 166:14
oral 10:1 15:11 40:18 44:7
orally 77:17
order 6:14 8:23 11:13,25 16:5 19:24 26:15 29:20 30:4,19 35:8 40:5 46:15 48:8 50:20 51:8 51:18 61:4 65:19 67:10 70:20 75:8 80:1 88:7,23 91:12 93:14 99:24 102:18 124:7 138:25 143:7 147:23 175:16
ordinarily 163:6
organic 167:25
organisations 25:20,22
organise 110:1
original 1:16 10:21 24:14 28:16 32:6 58:9 82:17 83:20 117:13 147:2,19 150:12 170:20 171:1
originally 28:2
other's 139:22
ought 48:25 102:17 142:15 153:17 159:25
oughtn't 142:16 153:19
outcome 42:24
outlined 58:9
outlines 27:1
outputs 29:19
outset 8:12 12:18 13:9,9 16:23 19:2 69:11 84:12 85:12 93:16,17 112:2 142:16 176:15 179:2
outside 41:25 42:10 138:24
outweighed 115:10
outweighs 175:23
overall 70:6
overcome 155:5
overdose 82:20 102:2
overlay 85:16
overlooked 38:11 151:20
overlooks 70:18
overlying 88:13 95:9
oversight 47:2,10 48:6 146:23 149:9,20 175:4 175:12
overt 11:1
overtly 155:16
overutilised 166:17
owe 139:20
owing 62:24
oxygen 159:19

P

page 10:14,14 11:16 22:25 26:22 97:2 101:5 109:13 131:10 133:2 135:13,14 135:14,18,18 143:9 150:1,6,16 150:17,17 151:18 161:7,11 169:3 171:9
pages 48:21 72:22 82:15 170:21
pain 93:2,3
panel 4:4 143:24
Panorama 82:22 178:19
paperwork 97:10
paracetamol 111:20
paragraph 10:21 11:12 23:3 28:16 32:6 74:8 83:20 98:25 111:10 117:11 150:4 169:3 170:20
paragraphs 62:17 110:5
Parc 2:17
Park 2:19
Parliamentary 3:10
part 17:21 49:4 53:8,12 60:14 67:3 70:10,12 75:24 76:10,13 77:1,4,10,12,22 78:4 79:9 81:2 83:9 99:21 127:2 154:24 161:17
particular 4:17 5:13,24 6:13,21 8:3 9:17,19 11:11 25:14 29:14,19 30:20 32:14 33:1 35:25 36:4 37:9 39:9 51:13 54:1 57:3 58:14,20 59:4 63:25 64:15 75:9 84:18,24,24 87:20 88:9 96:16 99:25 103:20 117:9 118:12 120:2,6 121:7 140:1 147:12 156:14 163:16 178:16
particularly 7:5,7 7:24 8:19 13:8 27:3 29:16 32:13 34:5,6 41:6 45:11 49:12 51:1 61:14 65:11 68:8 68:9 79:17 84:17 85:9 104:8 124:6 127:1 150:20 161:22 165:1 167:18 177:11
parties 97:22
partly 37:1 53:20
parts 164:21
party 174:15
Paschali 119:18 120:6 121:9,16 128:7
Paschali's 121:8 127:20 128:4
passed 87:22
passenger 123:6
passing 62:10
Paterson 64:14
patient 7:22 8:6,19 25:12 59:19 84:18 88:8 90:13 90:16,22 91:4 93:6 95:3,11 98:21 106:9 129:2 179:24
patient's 11:9
patients 7:3,11 20:24 33:18 59:20,24 84:21 95:19 157:5
pause 61:7 112:24 158:18
pausing 73:14 108:1
people 3:6,23 6:23 7:13 12:15 14:14 14:22 17:10,13 19:22 24:8 25:8 26:8,19 30:25 35:11,19,22,24 41:24 42:3,5 46:18 47:22 55:2 60:17 62:23 64:6 66:16,22 68:13 68:21 71:25 72:4 81:14 92:8 98:3 98:4 99:21 100:7 109:22 110:22 111:19 112:2 127:9,11 147:14 148:8 151:23 152:9 156:8,13 156:17 158:10 159:2,3 164:24 171:17 172:1 173:24,25 175:10 175:18 176:8,13 177:22,25 178:10
perceived 86:19 121:20 134:24
perfect 178:9
period 5:8 13:20 17:12,12 18:1,13 20:9,20 22:24 31:21 32:23 33:16 34:10 35:8 35:16 38:1 44:16 52:7 53:10,22 58:11,12 61:22 72:24 74:24 77:14 78:10,10 110:20 113:1 149:15 166:12 169:6
periodically 34:14

periods 167:2 168:21
permission 45:6
persisting 138:6
person 7:20 8:14 10:16,23 19:8 20:16 21:2 22:8 23:13,19 24:10 36:5,24 37:10,12 38:15 40:8 44:18 44:22,25,25 45:16,22 46:23 47:12 49:4,25 50:14 51:17,20 54:19,22 55:18 56:4,11,24 62:11 66:15 69:15 70:25 79:13 80:4 84:25 85:3 86:10 89:12 91:3,19 102:19 103:1 107:4 110:22,22 114:20 128:2 129:9,21 134:15 134:20 135:4 136:16 138:4 143:16 163:21 172:17
person's 11:20 16:1 29:1 36:4 48:24 49:13 51:7 59:8 98:13 105:25 106:12 112:12 170:9 173:8
persons 5:16 20:24 27:7 28:23 34:2 46:14 67:16 80:22 109:16 117:15 139:20 147:25 149:18 179:1
persons' 22:11
perspective 32:25 34:2 35:5 36:12 37:6 40:23 45:15 47:16 85:13 94:17 98:14
persuade 99:7 160:18
pessimistic 105:22
PHE 3:7
phone 95:7 131:19 133:11 180:13
phrasing 60:14 108:3
physical 3:23 10:16 14:8,12 19:6,13 36:13 38:17,21 40:14 84:16 85:1,8 86:7 91:1 92:3 94:16 95:15 147:4,16 161:25 167:8
physically 74:22 123:2 124:23 127:13 129:10 159:18
physiological 95:18
picked 114:25 115:2 177:23
picture 129:8
piece 12:9 135:12
pieces 126:6
pig 154:9
place 9:9,13 10:23 11:19 18:21 20:25 22:21,24 24:5 34:9,14 35:10 44:6 46:13 48:16 49:24 50:10 51:18 52:17 60:25 68:4 68:6 99:4 105:15 114:21 148:20 149:16 164:12 166:6,11 171:20 175:9,16,17
placed 61:4 88:12 102:1 103:24 133:6,8 134:1 135:25
placing 103:12
plan 133:20 159:11
planned 87:2 89:6 95:21 96:24 98:15 103:11 161:5,7
planning 11:20 19:21 20:1
plans 11:1,2
play 127:23 129:5 129:6
played 99:21 126:9,20 127:25 129:7
please 1:7 2:3 10:13,15 22:22 22:22,25 26:12 26:20,22 27:6 37:12 61:8 97:2 101:3 113:3 126:8,8,19 127:24 129:5,6 131:10,10 133:2 133:3,20 135:13 135:19 138:21 140:3 170:19
pm 113:3,5,7 126:15,17 158:19 158:21,23 181:2
point 13:7 19:8,10 19:19 20:21 24:9 29:25 33:3 37:9 45:14 71:22 75:17 80:18 108:5 127:5,14 128:19 129:1,15 129:19 132:15,20 140:12 150:8,20 158:18 161:13 162:15 175:25
points 123:5
polarised 156:13
police 73:3
policies 6:21 29:14 29:24 30:8 31:6 34:8,9,13,15,21 34:24 35:4,9,12 149:20
policy 3:6 5:3,4 6:23 22:23 23:22 24:2 27:7 29:13 29:21 31:11 56:1 57:10,14 60:15 148:19 168:10
poor 140:9
population 7:7 25:3 34:5 41:4 41:18 61:21 62:1 68:16 80:10 156:10
posed 56:3 172:4
position 17:5 20:25 29:17 44:10 51:15 60:22 63:20 75:5 109:23 124:3,23 128:16 132:16 142:19,23
positive 118:9
positively 68:8 72:2 89:17 91:25
possibility 13:10 108:10
possible 11:13 19:12 46:15 63:5 63:12 80:4 91:14 91:23 93:12 109:18 125:4 140:14 167:23 169:16 178:13,14
possibly 18:17 60:23 93:2 136:17
post 81:20
post-traumatic 41:1 134:20
potential 15:20 20:5 143:6
potentially 18:11 30:5 54:19 65:2 68:10,11 96:18 99:13 101:20 114:23 141:24 145:15 155:21 171:17
power 6:15
PowerPoint 26:13
powers 12:11
PPE 99:5 161:13 161:24
practically 143:1
practice 3:11 16:14,17 17:7 22:7 51:2 52:10 52:18 53:25 56:13 57:13 60:11,25 70:10 75:24 76:1 164:12 178:22
practices 140:10 145:16
practitioner 10:17 10:18 15:2 49:3 49:10 50:17
pragmatically 175:15
pre 20:23
pre-detention 12:15
Pre-emptive 151:16
pre-emptively 122:13
precautionary 151:14
precise 127:16
precisely 127:4 142:21
preclude 52:24
preconceived 99:20
predict 150:22 151:8
predicting 55:11 55:13
predominantly 2:10 32:8
prepare 26:15
prepared 1:10
preparing 4:25
prescribed 104:22 106:24
prescribing 11:2 107:14,20
prescription 107:19
presence 32:20 39:22 40:7 42:12 50:24 57:23 120:11

present 44:14 89:17 99:10 128:6
presentation 26:13 27:20,22 50:21 116:22 118:16 132:1 134:9,14 173:9,16
presented 161:22 162:1
presenting 104:18 144:10 155:15
pressure 45:23 85:5 159:16 161:17
pressures 47:15,25
presumably 58:3
pretty 33:14 88:10 88:10
prevailing 7:4 21:3 82:7
prevalence 61:23 68:15
prevalent 25:4 34:6 41:3,5,17 165:7
prevent 13:13 28:13 65:25 161:8
prevented 104:6 107:9
prevention 107:11
previous 87:11 93:23 116:7 141:16,22
previously 53:4 165:2
primarily 67:13 108:24 167:8 171:16
primary 7:10 8:2 10:22 17:16,19 17:22 36:3,17 42:3 66:11 94:18
Prince 4:15,19
principle 70:19
principles 69:25 80:13
prior 28:18 93:24 99:4 141:4 163:3 171:4,11 175:11
priorities 17:1,2 19:20
prioritise 36:1
prioritised 180:2
priority 17:4,18 18:3,5 21:5 32:18 36:16,19 61:3 84:16 88:11
prison 2:11,16,17 2:18,18,19,19 3:12,17 6:11 8:1 33:13 41:25 64:5 141:6 142:3 157:1 175:19 179:16,22
prisons 2:9,10,12 2:13,15 3:4,24 30:14 180:2
prisons' 179:6
private 2:17
proactive 33:9 152:9 153:18
probably 9:21 35:20 99:17 129:1 156:5
probation 3:18
problem 48:10 51:21 57:5 71:12 85:8 92:8 96:13 99:15 126:11
problematic 87:18 105:24
problems 56:20 96:11 118:14 164:5 165:3 178:4,6
procedure 84:1 86:8 94:24 95:5
procedures 35:9
proceedings 123:9
process 9:3 10:22 14:9 16:20 17:6 44:11,12 69:11 81:2 113:17 127:14 141:14,19 147:23 148:1,15 148:16 166:15 169:7 171:21 174:8,8 175:25
processes 17:17 46:11 106:8
produced 144:15
professional 8:17 96:20
professionals 7:21 65:9 66:8 96:10
Professor 62:16 180:25
profile 61:15
progress 86:7
progression 143:24
prolonged 168:21 170:2
promised 142:9
promote 63:16
prompt 50:11 70:16,16,21
prompted 49:11 104:2 113:17 116:24 127:1 144:14,18 168:22
promptly 7:14
proper 176:17
properly 111:10 157:5 176:4
prophylactic 107:10
proportion 61:17
proposal 171:16
protect 143:22
protected 147:14
protection 147:9 160:13
protective 64:6 147:6
protest 167:15
protested 103:12
protocol 91:12
provide 3:10 7:10 7:11 34:2 63:13 101:7 154:16 157:3,4 169:13 173:4,4 179:18
provided 25:21 26:17 30:22 32:21 33:3 34:9 34:18 35:7,11 39:1,6 53:7 58:10,13,21 63:10 74:15 83:1 88:4 96:14 98:10 101:10 102:5 103:23,23 104:14 113:20,24 116:23 119:2 139:14 169:8 173:22 175:22
provider 174:6 176:9
provider's 16:2
providers 80:20
providing 25:23 36:16 66:12 171:2
provision 23:9 26:20 36:9 49:11 52:7 53:21 104:3 154:15 158:7,14 179:23 180:6
provoking 78:23
psychiatric 63:14 71:10 73:17 154:1
psychiatrist 62:13 73:12,15,16 75:4 142:10 159:25
Psychiatrists' 63:20
psychoactive 156:4
psychological 71:10 167:23
psychosis 42:6 62:24 72:8
psychotic 41:9,15 41:20 72:8 153:25
PTSD 41:16 61:18 62:2,23 64:2 71:25 141:4,15 142:2,8,12,22 143:13 144:16 165:8
pulse 159:16
punishment 138:9 179:7
punitive 179:3
purely 7:20
purist 14:11
purpose 4:10 11:6 12:3,20 14:21 15:19,23 17:9 27:1 30:20 46:12 66:11 67:7 75:13 77:25 171:16
purposes 1:11 4:25 8:23 19:21
pursue 31:8
pursuing 22:13 109:12
push 130:2
put 17:12 79:25 94:13 95:3,15 97:1 98:20,20 121:14 124:2,23 127:21 128:16 133:11 149:15 161:8 176:24
puts 176:15
putting 108:1

Q

qualification 2:6
qualifications 2:2
qualified 43:10
qualify 41:2
quality 42:21 44:11 46:9,10,21 47:3 48:7 149:9 149:24 175:1,3 175:11
question 57:12 59:14,15 60:1 94:7 105:20 107:20 137:9 150:19 154:20 155:2 163:5 179:14
questioned 18:20
questioning 14:9
questions 1:25 47:24 82:1,6,10 117:8 123:13 179:11,11,12

180:18 181:13
quicker 77:3
quickly 137:12 138:1,17
quite 24:25 35:21 38:12 42:25 56:14 58:4 59:1 69:6 91:14 98:14 112:25 121:8 137:13 153:13 159:24
quote 98:17

R

railings 73:3
raise 82:1,6 89:6 89:16 125:6 151:21 152:6
raised 39:25 76:21 81:18 82:10 90:6 92:3 95:20 108:10 122:21 127:6,15,22 128:25 129:16 151:21 154:3,12 163:2
raising 34:1 40:13 166:21
range 36:12 63:14
ratcheted 99:24
rate 51:25 128:22 131:22 132:13,14 132:16,18,19,22
rationale 169:20
rationalise 130:1
re-evaluating 46:23
re-evaluation 46:14
re-experiencing 62:10 74:16
re-presenting 169:21
re-read 150:15,21
re-traumatisation 62:25
reach 110:21
reached 60:22 155:19
read 5:1,12,18 99:19
readjusted 18:4
real 65:10 107:8
realised 54:20 56:8
realistic 110:19
really 14:3 27:20 37:22 38:12 42:22,25 45:2 47:14 48:10 60:24 62:10 71:14 73:18 75:11 84:11 90:21 98:12 135:6 155:24 160:19 165:24 166:5 167:6 177:18
reason 17:21 21:11 31:23 32:16 59:12 76:25 79:16 85:20 99:1 105:21,21 108:20 108:21 109:1,11 125:4 128:23 162:3 169:12
reasonable 8:16 88:23 90:1 111:2
reasons 38:2 44:3 47:10 48:2 54:13 58:14 60:23 89:7 106:16 153:18,21 160:16 167:6,19
reassurance 45:3
reassure 101:23
reassured 45:20 45:21 80:3 153:22
recall 160:15
receipt 77:4
receive 45:16 74:13 76:10
received 30:25 31:10 47:11 73:6 76:13 101:18 112:10 114:18
receiving 43:4 70:25 91:3,6 106:22
reception 9:2 22:23
reciprocation 138:9
recognise 30:12 80:19 86:2 118:4
recognising 85:3
recognition 140:9
recommend 80:15 149:8 150:9
recommendation 139:11 150:2,2 161:4
recommendations 33:23 60:12 147:19 170:19
recommended 73:14,16 79:7 143:25 148:24 162:4 171:9
recommending 150:22
record 133:4 134:2 135:8 159:7
recorded 100:20 118:13 130:14,15 130:24 135:22 136:7 139:3
recording 26:23 43:22 67:18
records 5:9 10:2 22:11 40:18 49:18 66:20 67:19 73:22 99:19 103:4,16 103:22 104:20 108:18 115:1,12 116:5,18,18 132:22 133:1 138:14,21 141:6 142:17 167:3
recourse 164:9 178:11
recovery 63:16 128:16 132:16
recruitment 30:13
recurring 31:1
red 38:15 176:7
redness 133:17 136:3,4,11
reduce 140:13
refer 1:19 150:11
reference 1:14 11:11 59:4
referenced 61:24
references 24:15
referral 12:1 42:4 50:13 116:13 142:10
referrals 53:15
referred 14:1 42:6 94:10 108:11 114:8 153:1 161:25
referring 30:3 147:4
refers 150:4
reflect 23:19 111:11 149:19
reflections 179:19
refractory 86:23 100:8
refresher 30:18
refusal 16:11 28:5 69:20 116:24 159:10 161:16,21 162:7,17,21 166:24 167:2,6 167:14,24 168:14 168:22 169:6 170:3,10,16 174:2 177:6
refuse 15:13 116:20
refused 133:7
refusing 115:13
regain 172:18
regard 10:3 29:5 32:23 35:4 79:7 101:8,11 122:13 140:9
regarded 27:8
regarding 24:17
registered 10:18
regular 33:15 34:12 173:23
regularly 30:22 140:16
relate 30:23 33:17 38:25
related 153:15 165:14
relates 120:6 147:16
relation 16:14 25:5 28:24 32:7 33:5,21 34:8 39:1 42:16 49:2 57:4 58:6 64:11 70:7 74:9 75:4 77:12 82:18 83:16,21 88:5 89:2,5,15 91:9,22 95:21 96:25 98:15 100:5 102:10,12 106:21 112:4,18 117:9 118:21 120:8 121:6 135:13,15 135:15 139:10,14 146:13 148:16 150:3 151:15 152:8,13 159:8 163:19,20,20,25 166:24 170:9,24 173:5 175:18 177:11 179:14
relationship 39:5
relatively 34:10 138:1
relay 41:11 47:21 52:3 75:14 79:14 80:25 91:14,23 92:14
relayed 38:9 115:16 170:3
relaying 32:17 38:12 83:10 97:22
release 47:12 71:23 77:5 101:19
released 47:22 154:2
relevance 32:23

relevant 1:13 5:8 12:10 13:19 18:13 20:9 22:24 31:7,21 34:10 35:9,16 38:1 44:16 53:10,22 58:11,12 61:22 76:17 78:10 102:19 123:4,5,5
reliance 43:21
reliant 148:17 174:15
relied 40:3
relies 39:24
relieve 68:13
reliving 72:1
relocate 159:1
relocating 160:13
relying 41:8 46:2 97:18
remain 29:10 37:4 51:23,24 58:18 59:9 84:13 104:8
remained 103:1 112:20 115:12 128:8
remaining 6:24 20:19 38:15 56:4
remains 8:13,20 36:24 54:19,22 58:19 81:10 138:16
remarks 118:19 120:13
remember 74:7 109:2 115:1
remind 150:16
remotely 132:4 134:8
removal 3:5 4:7,9 6:5 7:4,9 8:3 9:2 9:4 25:3 26:9 30:13 36:11 61:16 64:22 87:3 87:23 88:3,24 90:11,19 93:20 94:19 107:11 110:5 119:22 164:21 176:9
remove 67:6 75:1 90:10
removed 6:25 7:15 66:16 103:13 133:9,12,12,15 134:1 135:25 136:2 137:24,25
repeated 168:21 168:25
repeating 52:13
report 1:17 9:18 10:21 11:16 12:6 12:25 13:3 18:24 21:21 22:3,9 24:14 28:16 29:7 29:8 32:6 42:12 44:22 46:21 48:20,25 49:6,12 50:4,5,9 52:17,19 52:23 53:4 54:4 56:16 57:7 58:8 58:9,21,22 59:2 64:25 69:21 72:22 73:6,23,24 73:24 74:5 78:25 79:11 81:16 82:16,17 83:1,4,6 83:6,12,15,17,20 84:10 85:21 92:21 93:5 94:7 98:25 100:15,23 101:4,5,7,12,19 102:4,5 104:3,14 105:16 108:15,17 109:3,13 111:10 113:20,22,24 114:3,7,10,13,14 114:17 115:7,15 115:18 116:8,9 116:23,25 117:10 117:13 135:15,23 139:3 143:9 144:15,18,21,22 147:1,2,19 150:1 150:7,13,15 151:18 154:6 162:12 168:23 169:4,9,14 170:19,20,21 171:1,10 180:8
reported 49:17 93:5 102:2 105:9 120:17 130:22 131:5
reports 1:10,16,20 1:24 4:25 16:15 26:16,24 29:14 31:18,22 32:3,7,8 32:19,22 33:24 37:20,22 38:14 39:4,18 42:16,22 42:24 43:5 44:15 44:16 47:3,11,23 48:20 49:19 50:20 51:3 52:9 52:11,20 53:2,9 53:21 54:14 56:17 57:23 58:11,12,14 59:13,16 60:2 69:5,18 75:5 76:1,22 77:1 78:8 81:5,10 101:4 102:20,22 103:3 117:18 119:13 138:18 145:5 149:10 168:16 172:11 177:3,7
request 22:12 23:6 23:11,16 105:14 105:22 106:16
require 23:6,15 55:5,7 64:25 70:13 148:1 168:1
required 7:24 10:9 14:8 16:16 19:13 85:10,11,25 108:6 130:14 132:25 136:22 142:20,21 143:8
requirement 57:14 77:6
requirements 14:25 20:8 57:10
requires 15:1 65:4 70:23,24 76:5
requiring 87:17 152:19
research 45:9 61:24
researchers 4:3
residential 159:2
resisting 161:14
resort 57:17 65:7 66:24 67:9 137:11,17 138:17 140:14 145:15 164:9,10,11
resorted 140:15
resource 34:19,22 143:6 179:17
resourced 34:13
resources 63:19 146:21
resourcing 18:6 20:1 37:2 109:23
Resp 131:21
respect 34:20 35:15 61:21 111:5 118:12 156:3
respects 69:6 72:17 132:23 163:11
respiratory 128:22 131:22 132:13,14 132:16,18,19,22
responds 88:15
response 23:10 35:5 66:21 70:23 70:24 77:3 80:6 85:16,18 87:12 100:8 101:15 115:8 137:12 139:4,7 144:23 165:18 168:2 169:10,17 178:5
responses 44:3 178:13
responsibilities 139:22,24 148:10
responsibility 16:1 16:2 25:25 27:5 29:17 46:19 109:23 117:24 118:3 157:13 174:6
responsible 26:4 42:7 52:5 131:2 148:9 156:24
resps 133:16
rest 27:19 180:11
resting 132:18,19
Restless 133:18
restrained 95:14 95:17 132:20
restraining 127:9
restraint 93:20 96:22 122:22 124:4 125:9,14 127:11 129:10,19 130:7,15 132:2 133:21 138:3 160:23 161:12
restraints 91:24 160:8,17,19,25
result 6:14 18:10 39:23 48:24 53:12 54:8 57:2 68:22 82:21 87:14 102:1,7 105:15 107:21 109:19 117:15 156:6 162:7
resulted 100:10
results 84:1
retention 30:13
retriggering 62:7
return 133:7
revealing 91:15
review 3:21 33:2 34:12 37:3,12 42:16 44:2,24 49:9,17,24 50:11 50:17 52:7 53:14 56:6 70:7,13,17 70:21 75:16 76:5 77:5,10 80:5 86:11 104:20 109:16 112:20 133:20 138:21 147:23 148:19 160:9 166:10 169:1,13 171:11

173:8,16 175:12 176:18
reviewed 7:14 10:1 13:2 34:14 51:8 110:3 143:24 146:18
reviewer 3:16
reviewing 27:6 45:25 52:5 137:2 144:2
revision 34:12
RGN 135:24
rhythm 92:24
right 1:14 2:9,23 3:12,19,24 4:15 5:5,10,14,20 6:16 6:25 8:10 9:5,10 10:10 11:10,22 13:11,20 15:15 16:8 28:20 30:23 31:24 33:10 34:3 34:15 37:5 38:3 38:7 40:10 42:17 44:20 45:5 46:17 48:25 49:15 50:1 50:2,22,23 51:11 54:20 57:18 60:15 61:19 66:6 70:14 71:17 72:12 73:25 76:6 79:8 89:8,18 101:13 103:6 104:20 105:19 106:10 107:3 113:12,25 114:5 115:18,19 117:4 120:22 125:10 128:6 131:22 142:13 150:6,14 158:14 165:10 170:24 171:7,14 171:18
right-hand 128:3
rightly 18:9 146:4
rights 48:14 154:18
ring 95:7
rise 126:13
risk 5:3 6:22 7:5 8:10 10:24 12:16 12:22 13:14 14:20 20:16,17 31:11 40:9 41:11 44:19 54:15,19 55:13,25,25 57:9 57:10,13,15,25 60:15 64:17 65:14,19,25 66:4 66:24 67:3,21 71:14,16 72:6 75:25 78:13 79:13,19 81:14 83:10,22 84:5 87:15 91:7 94:13 95:16 96:9,17 97:22,25 99:10 101:16 109:17 145:9 146:16 147:25 148:19 159:3 161:22 162:1 165:22 168:5,10 171:12 171:17 172:3
risks 11:1,14 18:18 21:13 56:3 62:20 70:11 91:14 93:21 151:21,22 176:11,15 178:6
RMN 133:10
robust 68:16 80:15 139:12 140:7
Rocky 98:17
role 3:1,2 6:5 7:9 7:21,25 8:7,8,12 8:13 12:4 16:6 89:2,15,19 107:22 121:8 123:17,18,21 137:8 140:9,23 148:12,13 154:22 154:23 155:1 157:10 172:6 173:18
roles 2:21 139:22 139:23
rolled 132:16
room 74:18 131:16 131:17 133:13,18 135:24 159:19
round 27:24 31:4
route 17:11 170:22
routinely 34:18 67:21 69:14 170:8,15
Royal 2:6,22 63:19
rule 5:3 10:4,9,12 10:15 11:17 12:4 12:6,9,13,17,20 12:25 13:1,3 14:5,8,21 15:1,1 15:4,5,10,13,17 15:23 16:15,16 18:15 19:7 20:8 20:8,9 21:20,21 22:3,5,8 23:4,19 23:24,25 24:11 26:15,21,23 27:2 27:11,11,16,19 27:20 28:24 29:16,16 30:4,5 30:10,23 31:11 31:18,22 32:3,7 32:19 33:3 35:15 35:15,17 36:6 37:13,20 38:14 39:4 44:15,22 46:11,21 47:11 48:18,19,25 49:2 49:11,11 50:4,5 50:20,20 52:9,11 52:13,17,19,23 53:3,9,9 54:4,4 54:13 55:4,5 56:16,17,21,24 57:1,7,10,14,23 58:6,7,11,12,21 59:2,6,6,13,16,23 60:2,19 64:18,21 64:25 65:2 69:4 69:10,11,15,17 69:21 70:1,1 71:23 73:24,24 74:5,5 75:5 76:1 76:5,10,15,22 77:1,21 78:5,7,19 78:24,24 79:11 80:2,8,14,17 81:4 81:10,16 82:11 83:1,3,6,6,12,15 83:17 84:9,9 85:10,20 92:21 94:7 100:15 101:6,12 102:4,5 102:10,10,19,20 104:3,14 105:1,4 105:8,9,9 108:17 109:3 111:5,10 112:18 113:20,24 114:2,2,7,11,11 114:13,17,21,22 115:2,7,17,18,22 116:8,9,22,25 119:12,22 133:6 138:10,18 141:18 144:15,18,22 145:4 147:21,23 148:16,19,25 150:3,6 162:12 162:12,14,14,21 164:17 166:7 168:14,15,15,23 169:9,13,14,18 170:2 176:2,3 177:2,7,21,21,21 177:22 180:8
rules 5:2 6:21,22 8:22,25 9:24 10:10,19 13:5,5 13:19 17:9,20 22:18 24:4 28:3 28:11 31:14 48:15,22 52:25 58:17 66:17 70:19 75:13 77:24 114:16 145:15 146:12 149:5 151:14 176:6,6
Rules' 10:14
run 95:12

S

sad 98:14
safe 80:1,4
safeguard 13:6,9 16:22 48:3 60:19 70:22 82:3 90:9 123:21
safeguarding 8:7 12:4 16:6 17:3 17:17,20 18:4,7 21:3 28:2,23 36:4,16,19 61:2 69:25 89:1,5,15 123:18 125:20,25 137:8 140:23 180:3,5
safeguards 7:6,11 9:1 31:8 37:17 46:6 54:25 58:2 61:5 69:8 74:25 81:8 100:6 105:11 117:4 146:8,22 163:13 177:17,21,25 179:9
safety 11:9 22:14 90:10 99:10 123:22 154:13 176:16
Salivating 133:15
sanction 89:18
sanctioning 99:15 145:16 163:10
Sandra 5:25 16:13 18:12 57:22 63:12 67:8,23 68:21 73:22 76:3 76:19 78:13 81:4 81:19 89:25 153:3 159:1
satisfactorily 60:8
satisfactory 60:13
saturations 159:19
save 90:9,23
saving 137:23
saw 27:18 58:4 82:21
saying 9:25 29:22 43:7 45:16 59:24 62:15 73:6 90:1 90:24 94:5 97:24 98:2 121:14 150:25 151:2 180:14
says 10:15 23:4

74:15 97:3 98:15 110:10 111:14 124:15 131:11,15 133:5 142:5,9 144:5,9 161:7,22 173:23
scarring 38:20,22
scars 38:18 111:13
scenario 55:12 145:9
schizoaffective 153:25
Schleicher 158:4
Schleicher's 6:2
school 24:18
screen 10:13 13:25 14:7,22,25 22:22 23:3 26:12 27:2 67:22 68:6 97:1 128:4 159:8
screened 171:17 171:19,21
screening 9:3,7 10:22 14:2 15:17 16:20 20:15 21:17 29:22 30:1 141:14,18 175:10
second 4:21 9:12 12:3 16:18 17:7 53:23 72:24 89:10 131:10
secondary 55:19 62:23
secondly 23:16 50:16 54:18
seconds 128:2,15 129:6
section 32:9,10,18 39:12 87:16 131:1 135:16,17
secure 2:22 3:4 11:21 14:14 33:7
security 65:22
see 10:13,15 13:23 19:1 21:6 23:3,6 23:8,14,20 24:15 26:3 27:2 29:15 33:1,15 36:14,15 38:19,21 40:17 41:23 42:8,10,20 46:18 47:1 55:10 56:10 63:2,11 64:4,4,10 66:19 67:3,20 68:15 75:22 76:12,17 81:1 85:13,15,18 86:5 88:4,11 90:7,24 92:9,15 93:13 94:17 99:5 99:23 102:3 109:10,25 119:19 120:10 122:11 123:3,14 124:3,7 124:12,15,21,24 125:2,2,7,17 127:9 128:3 129:8,9,13,14,23 130:4 131:11,13 132:23 133:2,4 135:21 136:5,14 138:15 140:18 143:18 150:24,25 151:9,11 152:24 156:25 158:10 159:8 160:4 165:7 167:15 172:21 175:9 178:15,19,21 180:7,11,16
seeing 36:9,10 50:24 139:6 179:8
seek 37:13
Seemingly 87:13
seen 5:25,25 6:2 8:1 15:11,18 23:5,7 28:21 29:10 30:4,6 31:4,22 33:8,20 34:23 35:3 38:14 39:5 40:18,19 47:22 50:8 61:20 73:11 74:11 77:16 86:24 91:22 106:15 108:13 113:18 116:4 117:17 120:13 121:8,9 122:15 123:7 127:16 131:16,17 132:2 134:3 135:24 164:23 167:2 175:22 176:20 179:20
sees 127:10
segregated 64:19 166:4
segregating 164:22
segregation 63:25 64:5,15 65:7 66:23 67:23 68:8 68:17 71:15 119:22 145:16 158:25 163:24 164:8,9 165:2,12 166:22
self-discharged 86:4
self-evidently 145:8
self-harm 11:2 28:13 49:14,25 50:18,25 62:20 64:17 65:17 66:10,18 72:5 77:13 79:13,24 80:7,11 82:8,22 84:3 91:2 92:4 100:21 106:20 111:12 113:21 114:4 119:14 137:13 139:5,7 155:16 159:3 161:8 162:15 163:25 164:5 165:14,20 167:1 168:5 177:12 178:3,7
self-harmed 82:19 115:14
self-neglect 4:22 151:20 160:7
self-strangulate 131:20 133:14 136:2
sends 176:7
senior 23:11 135:8
sense 14:12 40:21 45:8 67:15 79:4 81:13 113:2 127:10 137:20
sent 53:4 93:4 173:5
sentence 6:14
separate 141:7,13 144:7 177:19 178:14
Separation 64:20
series 100:5 163:12
serious 21:7,11 31:2 32:4 62:3 69:6 83:23 84:3 87:24 92:18 100:21 151:22 153:13
seriously 99:14
seriousness 136:14 137:3
served 141:3 142:1
service 3:10 155:22
services 17:17,19 17:22 20:2
set 69:8 92:21 122:14 179:22
setting 11:21 14:14 25:15 33:7 45:1,2 64:15 85:3 179:16,17 179:18
seven 141:8
severe 40:21,23 41:8,21 56:20 62:18 64:2 128:19 134:10
severely 4:23
severity 57:4 132:12,13
shadow 25:9
shame 112:3
shape 92:14
sharing 81:2,3 91:10,11,12 148:15 155:11
Shaw's 42:22 60:11
she'd 90:3
shield 98:18,19 161:13,23
shocked 58:4
shocking 33:14 58:7
short 61:11 113:6 126:6,16 158:22 166:11,12
shortly 154:2
shot 127:3
shoulders 97:25
show 22:22 99:12 115:12 116:18 129:20 159:7
showed 111:13
showered 160:7
shows 20:6 164:23
side 4:3 35:23 64:5 105:22 128:3 131:4 140:5 157:1 173:24 174:18
side's 96:16
sides 64:9
sight 37:7 106:7
sightly 112:23
sign 167:21
significant 11:3 18:5 20:5 21:24 35:1,2 38:12 59:1 61:18 67:15 71:23 78:25 81:11 91:24 95:18 98:11,12 105:10 149:13 174:3 179:1
silos 70:4 155:4
Simcock 1:3,5,6 1:23 61:6,9,13 112:23 113:3,8 126:10,14,18,21 128:1 129:8 158:17,24 179:10 179:13 180:22,24 181:11
similarly 105:6

simple 42:2
simply 9:23 38:15 39:9 40:13 43:6 49:19 50:5 51:2 52:23 78:23 98:7 107:14 114:13 125:14 150:5
single 1:24
sits 147:6
sitting 80:20
situation 90:12 99:25 123:3,6 129:23 134:25 172:8 178:9
situations 88:16
six 2:17,25 4:20,23
sleep 121:15 127:21
slide 26:13
slides 28:8
slight 133:17 136:2,4
slightly 107:7 158:17
slip 176:13
small 133:18
smell 159:22
smelled 159:19
so-called 121:10
socialise 74:19
socially 165:15
solicitor 152:18
solitary 178:11
somebody 15:16 30:2 38:11 41:12 46:19 51:13 68:3 80:1 94:17 109:6 143:18 156:10 164:18,20 180:14
somebody's 18:18 172:13
someone's 108:7
somewhat 17:1 134:15
soon 9:3
sooner 171:17
sorry 45:14 57:12 125:22 173:19
sort 14:11 19:12 24:3 50:6 55:9 64:9 69:23 80:11 84:16 88:3 99:24 119:4 137:16 155:19 180:3
sound 126:11,21
source 62:8
space 80:21 130:6 138:4
speak 84:23 91:18 172:14
speaking 26:6 142:20 172:23
speaks 80:9 106:6
special 7:23
specialist 42:5 63:18
specific 11:13 14:16 24:17,25 32:11,13 46:13 50:10 91:15 144:16 152:13
specifically 25:5 28:24 32:24 37:20 38:8 78:7 147:4 158:8
specifics 35:14
speculate 169:16
spice 154:10,14
spoke 84:15 142:1 160:12,15
spoken 85:4
stability 95:2
stable 92:20
staff 5:14,19 8:8 28:18 29:4,9,18 30:15 33:25 34:18 35:7 49:9 49:19 53:13,16 66:14 67:13,16 73:21 74:22 80:16,17 86:20 87:7 88:25 99:3 99:11 104:25,25 111:15 118:14,20 119:10 120:9 122:25 123:17 125:7 128:17 130:13 131:3 133:9,9,14,15,19 134:2,13 135:7 135:18,25 138:25 138:25 139:13,16 139:24 140:1,8 140:10,21 144:2 145:14 146:7,11 146:22 152:19 154:4 162:1 166:20 169:20 173:8
stage 13:3 19:17 53:23 74:4 93:22 101:8 102:5 114:23,24 115:2 115:20 116:13 117:4 127:7 128:7,12,18,24 129:17 162:18 169:1
stages 9:7
stakeholders 148:16
stand 117:11 138:2
standards 136:22
standing 109:24 122:10 127:3
stands 21:2
started 85:21 111:2 179:1
state 19:13 117:11 129:22
stated 87:12,16 88:19 100:16 169:18
statement 62:16 63:20 110:6,9 111:9,16
statements 5:12 93:23 148:7
stating 169:10
statutory 5:4 77:6
stay 93:1
stayed 74:18
step 14:15 68:6,17
stepping 100:4
steps 10:24 68:2 108:15 118:4,5 123:5
Steve 97:9
stimulated 127:19
stimulation 165:17
stop 38:16 55:21 121:11 125:14 130:3,7,7 177:25 180:9
storm 178:9
straightforward 88:11
strategy 3:6
stress 41:2 87:24 88:2,13 92:10 93:8 94:12,19 95:10,17 134:20
stresses 62:24
stressful 88:15
strikes 75:11
structurally 69:9
structure 179:20
structured 146:20 146:24
struggling 127:13 144:14
student 24:23
students 25:7
studies 49:7,23 58:15 59:5 117:7 145:12
study 82:14,15,17 112:25 113:10 169:5
subject 4:4 18:24 23:6 26:5 45:10 87:2 112:21
subjected 115:24
submit 108:17
subsequent 15:20 104:13 116:8 148:1 169:10
subsequently 14:23 16:24 83:15 103:13,23 115:13
substance 3:11 150:18 176:2
substances 156:4
subvert 112:9
successfully 103:21
suddenly 95:6
suffer 7:4 62:19,23 71:25 74:24
suffered 154:14
suffering 45:13 62:8,23 66:18 153:24
suffers 62:17
sufficient 28:1 34:18,21 175:16
sufficiently 30:11 30:12
sugar 159:18
suggest 23:13 68:16 95:2 125:5 145:13 150:2
suggested 171:1
suggesting 43:22
suggests 26:19 146:10 166:4
suicidal 11:2 49:4 64:3 65:17 66:10 78:11 79:24 104:24 113:22 114:4 119:13 141:16 144:6,6 144:11,19,23 145:9 163:25
suicide 28:14 49:15,25 50:18 50:25 54:15 58:1 62:20 72:6 73:2 74:4 77:13 78:14 79:13 80:7 84:4 100:18 110:10 151:22 155:16 165:14
suitable 46:9 65:4 84:12
suite 34:8
summarising 111:20
supervision 81:14 96:19 133:6 164:20
supplemental 1:17 11:16 29:8 48:20

49:6 58:8 72:22 78:25 82:16 101:5 109:13 150:1,7,15 151:18 169:4 170:21 171:9
supplementary 117:10 143:9 144:21
support 26:5 33:21 140:17 158:3 171:2
supported 30:9
supportive 129:3
suppose 37:6 43:14 93:11 117:20 120:20 156:11 175:15
sure 29:18 56:18 75:7 127:4 130:3 140:18 156:21 164:23 172:13
surgery 2:4 88:5 95:8
surprised 42:25
suspicion 49:3
suspicious 79:12
sustained 136:10
swallow 116:1
Swansea 2:18
swiftly 158:12
sympathetic 180:1
symptoms 38:7 39:10,21 40:1 41:15,20 62:7 72:9 83:25 93:2 95:1 104:19 118:17 135:10 144:10 153:25 164:5
system 21:1 34:11 37:16 42:15 43:18 44:1,6 46:5,13,22 48:7 49:24 50:10 51:18 54:9 69:4 72:17 78:19,20 80:15 111:4 112:5,9 113:14 139:12 141:21 145:23 146:20,23 147:21 148:21 149:9,14 155:4 170:2 171:1 172:25 173:1,12 174:21,21,24 175:5,9 176:16 176:17,17,21 177:2
systematic 50:19 147:8 148:2
systematically 51:8 143:7
systemic 43:3 48:10 52:6 69:12 69:18,21 71:11 99:15 109:21 117:3,7 119:8 141:17 145:2,6
systemically 70:6 177:1,5
systems 143:22 148:17 177:16
SystmOne 116:18

T

T-shirt 131:18
tacit 81:21
take 9:9,13 14:15 19:10 31:7 36:19 45:18,23 58:5 85:6 97:9 98:13 100:1 101:19 102:2 105:15 117:24 118:3 123:4 126:10 133:16 148:20 150:8 157:2 166:9 176:11
taken 10:24 27:24 27:25 41:21 44:7 45:2 82:20 85:6 86:3 94:21 99:4 99:7 108:16 133:18 153:22 159:17 160:3 162:8 164:9
takes 18:24 45:23 64:7 112:6
talked 42:23 84:3 156:7 176:12 179:16
talking 25:7 84:19 96:25 150:6 173:20 177:20,24 178:1
task 7:20,24 29:19 40:12
tasked 87:23
tasks 30:20
team 4:2 22:13 42:5 114:25 144:9 145:25 153:2
team's 35:5
technically 88:6
tell 130:3
temperature 159:18
templates 26:23
temporarily 45:4
ten 18:14,18 19:5 19:11
tend 25:8 95:1
tendency 38:17 167:5
tends 65:25
tenures 3:1
terminology 135:3
terms 1:13 14:13 18:23 31:11 40:17 42:23 44:8 45:25 47:18,18 47:25 52:13,14 61:15 65:21 94:16 96:21 106:8 107:5 109:8 110:1,25 119:3 129:19 130:2 136:22 138:5,8,22,23,24 139:7 145:11 146:2,20 149:19 149:20,24 157:16 167:18 174:10
test 153:20
thank 1:10,22 23:1 61:6,9 113:2,4 127:24 158:20 179:10,13,13 180:18,19,21,24 181:1
theirs 120:19
therapeutic 63:16 63:24 65:10 71:7 71:9 79:20 165:25 178:12
therapeutically 65:18
therapy 63:6,9 71:11
thereof 146:23
Theresa 6:2 158:4
thing 44:21 99:18 119:23,25 129:22 157:3 163:9
things 18:2 28:9 28:10,25,25 30:17 33:15 34:24 35:3,6 36:13 45:18 49:17 55:14 64:1 64:9 70:2,20 93:19 94:2,20 101:23 118:8 122:13 123:8,14 123:15 124:22 125:19,23,24 143:5 146:3 149:16 156:5,6 157:1 174:1,18 176:22
think 1:18 2:7 5:9 5:13 7:1,1,23,23 9:15,21,25 11:11 12:13 14:11 16:1 16:9,24 17:15,25 18:1 19:18,20 20:25 23:24 24:3 25:25 26:3,15 27:23 28:2 29:16 30:17 31:4 34:23 36:17 38:2,8,10 39:17 42:4 43:2 43:8 45:5,14 46:12 47:19 48:16 50:6 51:12 53:24 55:12,15 56:17,25 59:18 60:21 66:21 68:2 72:14 80:18 82:5 84:25 85:14 88:2 91:8,9,23 92:7 93:1,14 95:16 96:13 97:21 98:14 99:17 106:18 107:23 108:25 110:13,16 110:17,25 112:10 114:19 117:21 119:1,2,4,20 127:17 129:1 130:7 137:21 139:25 140:12 143:18 144:17 147:1,2 149:4,4,6 149:6 150:3,12 150:13,15,17,20 150:22 154:18,20 154:22 155:5 156:24 157:11 166:7,23 168:7 172:9,9,10,18,24 173:22 174:20,23 176:7 178:14,20 179:7
thinking 175:15
thinks 23:15,15
third 125:14 174:15
thirdly 51:6 91:17
thorough 18:24 19:25
thoroughly 18:18
thought 85:22 166:20
thoughts 144:19 165:13,14
threat 81:15 99:3 121:18
threatened 64:8
threatening 134:24
three 3:14 26:21 27:19,24 28:11 104:19 126:6

136:21 141:13 152:23
three-quarters 31:22 39:18 44:15
three-year 3:1
threshold 50:4 56:21 57:4 58:1 58:16 59:22 60:7 81:5,12 101:16 103:9 155:19
thresholds 52:19 149:2
tick 14:12
tick-box 14:10
tied 74:3 131:17
time 6:18 13:7 18:1,13,15,22,24 19:23 22:21,24 23:22 24:21 25:6 30:16 33:4,16 34:18,21 37:9 45:19 51:10 52:7 52:24 60:22 61:7 74:15,22 75:17 90:21 95:11,21 99:6 101:17 103:1 104:3,17 104:23 106:20 109:9 110:20 111:7 112:6 113:1 114:9,23 119:23 120:15 121:21,25 122:22 130:16,19 135:21 141:11,11 143:10 147:22 149:15 153:20 154:16 162:15 166:12 167:7 173:9 179:4,5
timeframe 176:24
timeline 110:25
timeliness 12:13
timely 49:10 50:11
times 35:21 122:18 137:9 154:14
today 1:3 13:20 20:10 138:16 174:1
toilet 131:20 133:13 136:1
told 22:1 74:17 111:9 121:11
tomorrow 180:24
tool 65:24,25 66:5 71:17 79:19,23 120:11
tools 8:18 55:15
top 33:18
torture 5:20 21:19 22:2 24:18 25:20 27:8,13 32:20 38:6,9,10,18,20 39:23 40:9,16 41:6 43:16 44:18 44:23 45:10,17 46:15,20,24 62:2 62:6,10 74:16 109:17 114:20 150:5,11 174:3 180:15
tortured 30:3 62:11
total 74:24 143:12
totality 134:6 136:20
touched 44:13 61:16 75:23 165:2
track 174:4
tracks 180:9
train 31:6 139:15
trained 43:11 135:7
trainees 25:7
training 24:12,17 24:19,20,22 25:4 25:17,21,23 26:4 26:6,11,14 28:4 28:18 29:4,9 30:9,10,18,18,22 30:25 31:10,16 32:3,11,13,15 33:5,9,20,23,25 34:19 44:2 47:19 79:7 80:16 139:12,14 140:7 140:17 148:2,25 149:8
trajectory 44:8
transcript 96:23
transcripts 5:18
transfer 51:20 73:14,20 103:11 104:12 105:14,19 105:22 106:5,12 106:14,17 108:14 111:1
transferred 73:17 103:21
transferring 105:24
trauma 34:5,6 62:7 72:1 143:3
trauma-based 71:11
trauma-focused 63:6,9
trauma-informed 33:24
traumatic 111:24
travel 87:13
treat 16:5 109:7 119:9
treated 14:4 15:4 87:4 118:24 142:13 178:4
treating 109:8
treatment 12:1 63:14,19 66:12 71:10 72:10 74:13,14 85:25 100:7,9 106:23 107:3,5,10 110:18 142:3,21 143:14 152:6,17 157:22 169:19
triage 19:15,18,22 20:3 23:5
tried 133:10
trigger 53:13 93:8 103:8
triggering 51:2 52:20 56:15
TRN0000087 97:2
true 70:17 132:23 137:3
truly 140:21,22
trust 112:10,11
try 99:7 110:23 124:25 125:1 126:12
trying 31:8 45:5 61:3,3 86:7 112:8 133:10 180:4
tucked 97:10
Tuesday 181:4
Tulley 97:3,6,12 98:18 118:13 130:10,12
turn 24:16
turnover 30:15
turns 153:24
two 1:10,16,20 3:1 9:7,9 13:5 14:2 17:9 20:4 29:22 35:24 49:20 52:20 58:10 64:9 73:2 91:8 92:21 92:22 111:12 114:15 118:8 139:19
two-hours' 30:1
type 25:3,14,18,23 40:12 41:20 55:12 66:5,25 135:3 139:24 178:18
types 13:18 33:5 57:18 120:12 139:6 165:19 170:24
typo 150:5

U

UK-wide 3:3
UKHSA 3:8
ultimately 18:6 25:25 52:4 92:17 93:18 114:19 156:11 174:5
unable 133:16 151:23 152:1,4
unacceptable 89:24 98:10 137:6,7
unaddressed 149:14
unanchored 138:20
unavailable 103:1
unchecked 120:22 137:10
uncommunicative 159:15
undergone 83:23
underlines 24:3
underlying 30:20 64:13 69:25 79:24 92:10 134:9 142:11 143:19 165:19 166:25 167:19
underneath 145:25 160:4
understand 6:19 9:15,23 17:21,23 20:11 21:4 26:3 26:10 32:25 62:5 113:16 118:14 129:18 136:8 137:22 140:21,22 148:10 161:2
understanding 6:4 6:17 7:2,17,22 8:14,22 9:14,18 9:21 10:8 12:14 13:4 14:15 15:6 15:10,11,24 18:2 19:16 20:13,14 21:22 24:4 26:24 30:16,19 31:3,5 31:13 32:16 34:3 35:11 38:19 39:2 44:17 45:9 47:4 47:5,15,17 48:13 48:22 52:12 58:17 61:2,20 66:12 67:1,14,24 68:23 70:15 75:6 75:12 76:7 79:9 96:21 110:25 114:16 131:3 139:21,23 140:8

147:5 148:5 159:4 165:21 167:11 172:15
understood 9:16 14:21 17:24 29:18 67:7 95:17 130:12
undertake 18:17 19:24 75:8
undertaken 12:17 59:7 75:17
undertaking 14:22 96:20 97:23
undiagnosed 41:1
undoubtedly 156:3
unfortunately 33:12
unhelpful 55:16
unilateral 44:10 60:22 78:3
unilaterally 53:25
unintentional 162:19,20
unit 64:20 154:1 164:18,25
University 2:5
unnecessary 54:5 54:6 100:11 161:21,23,24 163:16
unqualified 178:10
unstable 94:12,15
unsuitable 27:9
untreated 106:21
unusual 155:15
unwell 4:23 42:4 64:22 71:8 73:18 86:24 87:5 99:10 111:18 128:20 134:11 159:9 160:2 166:3
unwilling 103:2
update 173:4
updated 34:14,24
updates 35:4
uphold 172:21
upset 131:18 132:7
uptake 175:1
urinating 159:10
urine 159:20
use 5:9 8:17 28:13 34:20 50:20 53:9 54:1,9 56:21 57:1 58:16 59:5 67:22 68:17 78:3 82:8 87:2 88:17 89:2,6,7,7,10,18 89:19 90:9 91:5 91:7,24 92:5 94:3 95:21,24 96:1,7,25 97:19 97:23 98:2,16,18 98:23,24 99:15 100:11 103:14 112:21 115:17,25 119:25 120:1 121:7 123:17 130:10,12 132:25 133:22 134:2 135:14 136:7 137:12 138:17 139:4,7,10,14 140:13,15,17 145:16,17 147:21 148:3 156:4,4 158:25 159:1 160:22,25 161:5 161:6,7,10,13,18 161:19,23 162:2 162:9 163:1,3,7,7 163:8,8,16,24 164:17 166:16,22 170:1 177:10,11 178:11
useful 175:19
utilised 22:14 58:15 155:10
utilising 58:23

V

V2017042500021 126:7
value 9:19 172:18
variable 35:21 110:21
variety 41:25
various 2:8 5:2,4,7 49:18 72:17 94:20 117:3
vast 38:13
verbally 27:23 28:7 74:23
Verne 103:12,21 104:12 105:15 108:14
versed 88:7
versus 40:21 42:3
veteran 141:3
vicinity 128:8
victim 21:19 22:2 27:13 39:23 40:8 40:15 43:16 45:17 46:20,24 62:6 109:17 180:15
victims 24:18 41:6 45:10 46:15 150:4
Video 126:9,20 127:25 129:7
view 13:23 17:2 19:15,24 25:22 27:21 28:6 29:3 29:10 31:11 35:18 38:2,22 50:3 53:12 54:8 58:15,18,19 59:10 64:14 70:1 74:6,14 83:5 86:12,13,14 92:2 93:6,14 94:14 96:6 98:13 99:12 101:10 102:8,16 103:2 110:17 111:21 113:23 114:6,12,16 116:25 117:8,19 118:6 119:1 127:2 131:25 139:22 140:11 148:4,22 164:3 168:23 173:17 174:12 178:16,17
viewed 32:22 117:18 154:22
views 100:1
visit 4:21 23:7 87:11 152:24
visited 4:10 159:14
Visual 131:20 133:16
visually 124:2
vocational 24:19
voice 172:22
volume 35:19
vulnerabilities 8:9 12:22 16:25 21:17 51:14 70:11 75:25 84:24 91:2 92:4 143:16
vulnerability 57:3 67:22 70:7 115:11 154:13 158:1
vulnerable 7:7,12 7:19 8:19 13:14 27:3 45:11 51:23 51:24 55:17,23 60:18 64:11,16 68:3,9 71:3 87:4 100:7 111:21 143:22 146:16 159:3 171:25 175:14 177:22,23 177:25

W

wait 47:1 86:4 151:11
waiting 17:12 56:10 80:3 86:8 95:4
Wales 2:15,18
walked 133:18
walking 74:20
want 7:1 8:25 22:20 24:11 29:17 33:1 35:14 42:11 51:17 52:3 61:13 72:21 74:19 89:7 93:21 107:12 117:7 120:5 123:12 126:6 140:15 155:3 157:12 158:24 170:18
wanted 107:4 110:11 111:19 117:16 151:1
wanting 124:25
wasn't 10:2 19:12 21:19 22:16 24:21 27:22 30:10,12,22 31:1 32:12 46:13 50:5 51:2 56:13 59:22 63:9 66:23 67:8 67:19 69:4,15 71:8 74:21 77:9 79:16,17 85:22 89:25 90:3 91:20 93:15 100:18 102:4 105:3,5,9 106:22,22 108:8 108:9,13,23 111:14 124:16 125:4 128:22 130:14,15 142:13 142:14 145:3,23 146:25 155:14 162:11 163:22 167:18,20 168:4 168:6,14,17
watch 5:24 78:12 78:12,22 131:17 133:8,19 163:22
watched 5:22 9:20
Watson 2:25
way 13:5,18 18:5 24:6 40:22 41:2 45:3 56:13,19 63:23 64:6 67:20 74:8 77:2 84:23 92:14 95:3 97:13 97:24 98:9,10,21 105:24 108:1 117:25 129:3 132:22 136:13 142:14 143:18 146:20,24 154:14 155:9,10 166:16 174:20 175:2 176:5 179:21
ways 71:7 98:5

117:6
we'll 97:8
we're 55:13
we've 97:7 176:12
weak 161:16
Webb 97:5,7,13 98:17
weeks 20:4 25:10
weight 172:24
welfare 89:12 118:15 122:8 123:22 125:9,20 125:25 129:20 159:25
well-being 11:9
went 69:23 117:23 120:2 133:13 136:1
weren't 30:9 34:11 36:21 43:23 49:19,21 52:21 52:22 54:1 67:18 67:21 69:5,24 71:22 78:23 84:6 118:15 131:4 146:10,17 156:12
whilst 11:20 62:24 67:12 72:2 80:2 82:25 83:25 84:4 103:17 104:3 142:6 144:7 154:15 157:21
wholly 156:9
widespread 137:13
Williams 160:3,12 160:15 163:1
wing 64:21 66:9 67:12 68:14,22 74:2 80:22 116:1 116:5,8 133:7,7 135:24 152:18,24 154:4 158:25 159:2 160:5 163:22 180:14
wings 159:2
wish 1:19 15:25 43:9
withdrawal 11:6
withdrawn 138:2
withdrew 155:17 180:23
witness 1:3 5:12 62:16 110:6 111:9,16 148:7 168:13 179:11 180:23
witnesses 5:19
wonder 126:10
word 45:5 55:15 92:25
words 29:25 54:22 64:19 118:3,10 127:20 157:7 166:15
work 2:12 9:17 13:6 17:10 26:8 28:19 39:1 80:21 149:13
worked 2:8,14,15 2:16,18 4:8 8:2 38:24 75:1 180:16
working 2:11,20 3:3,5 4:6 5:13 25:2,24 31:9 32:2 56:13 64:5 144:24 145:25 174:18,21,22,24 176:8 180:12
works 25:14
worried 37:10 95:5 97:4
worry 19:9
worse 64:1
worsen 62:20
worsening 83:11 93:7 102:6
worth 18:22
worthless 110:8
wouldn't 20:23,24 24:24 76:11 81:23 90:12,16 95:5 107:9,12 125:15 134:23 140:15 157:10,11 170:13 174:16,22 177:3
wrestled 155:2
wrist 115:14 161:8
write 57:7 60:2 136:18
writing 50:11 54:4
written 16:15 54:3 74:7,9 77:17
wrong 98:5 163:2
wrote 9:17 90:25 94:1

X

X 67:6 181:7

Y

Yan 119:18 120:6 121:8,9 122:2 127:20 128:4,7
Yeah 156:24 175:15
years 2:12,17,25 33:13 47:8 78:9

Z

0

07:05 126:8,18
08:25 126:8,18
08:38 128:1
08:42 128:2
09:30 128:15

1

1 52:16 72:23 73:11 119:13 177:7 181:9,11
1.55 113:3,7
10 2:24 18:22 19:1 102:3,16 105:6 108:12 127:23 135:13
10-minute 18:20
10.00 1:2 180:24 181:4
10:00 128:15
100 47:9 81:7 89:24
104 159:16
11 10:14 135:18
11.26 61:10
11.40 61:8
11.46 61:12
11.50 159:14
12 129:6
12.55 113:5
124 98:25
13 73:23 83:9 103:11 104:18 105:15 110:4,10 110:15 112:19 114:7 115:7 152:22
15 2:12 3:20 33:13 101:6 105:2,8 106:25 107:19 111:5,12 158:19
158 111:10
16 131:21,22 132:13,14,17,17 132:22 133:16
17 83:16 92:20 100:15
179 181:13
18 115:8
18:51 133:3
19 74:3 87:9
19:00 133:8 135:23
19:01 131:12
19:40 131:12,16
194 110:5
1998 2:5

2

2 30:5 37:13 40:9 52:16,25 54:5,13 57:23 69:4 73:11 76:15,22 77:24 161:7 176:2 177:3,7
2.17 126:15
2.21 126:17
20 97:2
20:00 133:17
2006 2:7,10
2015 26:14 72:25
2016 141:7,8,9,10 141:12
2017 6:8 31:9 32:8 59:16 63:10 72:23 73:9 74:3 77:14 78:8,10 82:19 83:9 87:9 88:19 98:24 100:15 101:6,25 103:11 110:10 113:11 114:7 115:15,24 135:22 143:24 145:5
2018 141:10
2020 157:25,25
2022 1:1 181:4
21 22:25 141:10,12 143:24
214 110:6
23 82:15 141:9
24 9:13 10:8,19 11:7 15:9 16:17 18:13 23:9,14,20 115:4,15 141:7
25 115:24 116:3 131:11 135:22
25th 116:13
26 101:5 116:4,16
27 88:19 94:1 95:21 98:24
28 1:1
29 48:21 181:4

3

3 3:21 37:13 76:15 77:25 161:11 176:2
3.08 158:21
3.25 158:19,23
3.3 117:11
3.58 181:2
30 48:21 82:15 128:15 129:6
31 74:11
31-year-old 4:19
33 10:19
34 10:4,9,15 11:17 12:4,9,13,17,20 13:1,5 14:5 15:1 15:4,13,17,23 16:16 19:7 20:8 20:8 21:20 29:16 69:10 70:1 74:24 114:21 141:18

176:3,6
34-compliant 18:15
34/rule 28:24
35 5:3 12:6,25 13:3 13:5 14:21 16:15 20:9 21:21 22:3 22:8 24:11 26:15 26:21,23 28:24 29:16 30:10,23 31:11,18,22 32:3 35:15,15,17 36:6 46:11,21 47:11 52:11 59:23 69:11,15,17,21 70:1 71:23 75:5 76:1,5 77:1,21 78:5,19 80:8,14 80:17 92:21 94:7 105:1,8 109:3 111:5,10 112:18 138:10,18 141:18 147:21,23 148:16 148:19 164:17 168:14 169:18 170:2 176:6 177:7
35(1) 30:5 37:13 48:25 49:11 50:4 50:5,20 52:25 53:9 54:4,13 55:4 56:16,17,21 56:24 57:1,7,23 58:11,21 59:2,6 59:13,16 60:2,19 64:25 69:4 73:24 74:5 76:15,22 77:24 78:24 83:3 83:6,12,15,17 84:9 85:10,20 100:15 102:5,10 102:19 105:4,9 108:17 114:2,11 115:17 116:8,22 116:25 144:15 150:3 162:12,14 168:15,23 169:13 176:2 177:2,21
35(1)s 58:6
35(2) 49:2,11 50:20 53:9 58:7 58:12 59:6 65:2 73:24 74:5 78:7 78:24 79:11 80:2 81:4,10,16 82:11 83:1,6 84:9 102:4,10,20 104:3,14 105:9 113:20,24 114:2 114:11 115:18 116:9 119:12 144:18,22 145:4 162:12,14,21 168:15 169:14 177:21
35(3) 22:5 27:11 27:16,20 30:4 32:7,19 33:3 37:20 38:14 39:4 44:15,22 48:19 52:9,13,17,19,23 53:3 54:4 101:6 101:12 114:7,13 114:17,22 115:2 115:7 150:6 169:9 177:21 180:8
35s 76:10 166:7
37 139:4
38 133:2

4

4 113:11
4.7.5 169:3
40 64:21 66:17 72:22 119:22 133:6 177:22
42 66:17
48 72:22

5

5 82:19 101:25 113:19 159:8,8 160:4
5.261 83:20
50 169:3
504 141:10 143:13
55 159:16
56 11:16
59 150:17

6

6 32:9,18
6.1.3.5 28:16
6.2.2.4 10:21
6.2.4.5 32:6
6.5.16 170:20
6.5.6 147:20
6.5.7 148:14
60 150:1,6,17
61 170:21
62 170:21 171:9
64 143:9
67 151:18

7

7 131:16,17 135:24
76 159:16

8

8 73:20 108:9 131:10 141:10
81 109:13

9

95 62:17
97 62:17
999 95:7