the following diagnosis related to mental disorder:

190. ICD-10 F33 Recurrent depressive disorder / Psychosis / Bipolar Affective Disorder

191. Recurrent depressive disorder is defined within ICD-10 as follows:

192. "*This disorder is characterised by repeated episodes of depression…without any history of independent episodes of mood elevation and over activity that fulfil the criteria of mania…The age of onset and severity, duration, and frequency of the episodes of depression are all highly variable…*" A diagnosis of severe depression includes, "*depressed mood, loss of interest and enjoyment, and reduced energy leading to fatigability and diminished activity"* as well as, "*at least four other symptoms, some of which should be of severe intensity."*

193. In my opinion, **D687** suffers from recurrent depressive disorder, however it is also possible that he may have now developed a psychotic illness such as Bipolar Affective Disorder. The diagnosis of depression would be indicated by his past history of suffering from previous episodes of depression which appear to have started during his early adult life and have been recurrent. It is notable that there are reports that he attempted to hang himself whilst at Feltham prison in 2001. His health records state that on 8 December 2009 he outlined having a history of depression and described symptoms of sleepiness and low self-worth. His condition is likely to have fluctuated in severity at different times but would have been present when detained at Brook House and during the 2017 suicide attempt on 13 May 2017. **D687** described suffering from increasing symptoms of depression throughout 2017, following the death of his brother from throat cancer the previous year. In my opinion, his depression is likely to have continued to worsen after the suicide attempt on 13 May 2017. It is notable that on 14 May 2017 he said that he had enough and his sleep pattern was not good and that he wanted to see a mental health nurse and was booked to have a medical appointment to consider treatment with antidepressant medication. In my opinion, he should have been seen by a doctor regarding his mental health on

the day of the suicide attempt and that it was a failure in care in delaying commencement of antidepressant medication. It is notable that prior to the suicide attempt on 13 May 2017, he was already noted to be distressed by having received negative news from the Home Office and was tearful when talking about events in Somalia. When seen on 15 April 2017 by Dr Oozeerally for a Rule 35 Report he disclosed his past history of trauma, previous suicide attempt, outlined he was hearing voices and was getting stressed and emotional and had difficulty sleeping and was also observed to be tearful. Dr Oozeerally noted that he was not taking antidepressant medication but remained under the care of the mental health team. In my opinion, this is a clear failure within in his care as it should have been identified that given his past history of self-harm, disclosure about previous trauma and unstable mental state that he should have been prescribed antidepressant medication at that stage and encouraged to take the medication. In my opinion, he would have been at high risk of attempting to commit suicide and Dr Oozeerally should have foreseen that this was a risk that could have been mitigated by the prescription of antidepressant medication and alerting to the officers on the unit to be vigilant to his risk of self-harm and to have a low threshold for initiating an ACDT plan if required. In my opinion, he should have also been referred to the Consultant Psychiatrist for a specialist assessment of his mental health treatment needs given his complex presentation. It is also notable that his health records outline that he was presenting with a range of unusual and bizarre behaviours which are likely to have indicated that he was either suffering from high levels of psychological distress or developing a psychotic illness, which further highlights the need for him to have had an urgent referral for a psychiatric assessment at that stage. In addition, it should have been evident to Dr Oozeerally that he was at risk of harm within detention and the Home Office should have been urgently advised about this and the appropriate form completed and submitted to the Home Office so that they could consider the need to urgently release him from detention given the harmful impact that this would have had on his mental health. These interventions did not take place and it was only several days after his suicide attempt on 13 May 2017 and his increasing symptoms of depression, that he was prescribed antidepressant medication, initially in the form of Sensitive/Irrelevant per

day by Dr Fowler on 16 May 2017. This was a few days after he arrived at The Verne IRC, following him being transferred there from Brook House IRC. Dr Liebenberg a psychiatrist later added Sensitive/Irrelevant (antidepressant medication) which was then prescribed in combination with Sensitive/Irrelevant which in my opinion highlights the severity of his depression at that time.

194. In my opinion, D687 has suffered from a worsening episode of depression since his recent imprisonment at HMP Durham. This would be indicated by his account of suffering from low mood and a range of depressive symptoms, objective presentation upon mental state examination and his results upon psychometric assessment. D687 described suffering from worsening low mood. He has experienced difficulty falling asleep at night-time. He has also suffered from nightmares which have prevented him from sleeping. He has suffered from tiredness during the day-time, low energy levels and does not enjoy anything in life but manages to go to the gym once per week. He described suffering from poor appetite and said that he does not eat breakfast and only has one meal per day. He described having to force himself to eat. He has also experienced tearfulness, emotional problems and described crying frequently. He outlined suffering from poor concentration and has noticed problems with his memory. D687 has also become hopeless about life and expressed thoughts about not wanting to be alive. He described having thoughts about self-harm and suicide including thoughts to throw himself down the stairs or hang himself with a sheet and said that he has been having such thoughts for several years, but they have been worsening in the last few months. He said the only thing that has prevented him from acting on these thoughts is his younger siblings who he said are a protective factor for him. He described hearing voices during the last 5 to 7 months, but said they have started to improve with treatment with his current medication which includes Quetiapine which is an antipsychotic drug. His description of hearing voices appeared to be in keeping with severe underlying emotional distress. He described feeling paranoid and said that he felt the Home Office was against him. He told me that he sometimes thinks the food in the prison is being poisoned and that someone is going to attack him and that he did not trust the prison officers. In my opinion, his

description appeared consistent with underlying paranoia due to severe psychological distress verging upon the development of persecutory delusions. Clinically, he presented as an individual suffering from severe symptoms of depression as indicated by the number and extent of his symptoms and the impact they have had upon him. Objectively, he presented as agitated, distressed, paranoid and suspicious.

195. In my opinion, the diagnosis of depression is supported by his health records which outline that he has a long history of presenting with low mood, depression and incidents of self harm and attempted suicide. His health records outline that he is reported to have attempted to hang himself when at HMP Feltham in 2001. On 8 December 2009 he attempted to strangle himself with a t-shirt. As outlined earlier on 8 December 2009, he had described symptoms of sleepiness and low self-worth and a history of depression. Following the death of his brother from throat cancer he was prescribed antidepressant medication initially in the form of **Sensitive/Irrelevant** per day by Dr Fowler on 16 May 2017. Dr Liebenberg a psychiatrist later added Sensitive/Irrelevant (antidepressant medication) which was then prescribed in combination with Sensitive/Irrelevant He has suffered from a further deterioration in his mental health since his imprisonment at HMP Durham and has developed manic symptoms. He has had a flight of ideas, pressure of speech and presented as paranoid. Dr Chakrabarti noted on 25 February 2021 that he had persecutory delusions and commenced treatment with Sensitive/Irrelevant Sensitive/Irrelevant (antipsychotic medication). In my opinion, there is therefore a possibility that he may be developing a psychotic illness such as Bipolar Affective Disorder, however this will require further monitoring and evaluation as his symptoms could also be explained by psychomotor agitation due to depression and high levels of psychological distress. If further information becomes available, I would be happy to update my opinion as to whether he suffers from recurrent depressive disorder or Bipolar Affective Disorder.

196. In my opinion, his condition has considerably deteriorated since he was assessed by Dr Obuaya, Consultant Psychiatrist on 4 July 2017. In addition, Dr Obuaya did not have access to all of the relevant health records to form an

informed opinion on his diagnosis. In my opinion, if Dr Obuaya had access to his full records, as I have done, then he would have seen that he was reported to have attempted to hang himself at HMP Fetham in 2001, had panic attacks in 2010, reported attempting to jump off a bridge in July 2013 and had thoughts to hang himself on 1 April 2014 whilst at HMP Wormwood Scrubs. In my opinion, his past history of low mood, depressive symptoms and suicide attempts are not in keeping with an adjustment disorder and Dr Obuaya is more likely to have diagnosed recurrent depression rather than an adjustment disorder if he had access to the information that I have been able to review.

197. I completed the PHQ-9 Depression rating scale with him, on which he scored 21 out of a possible 27. This is a rating scale to help augment diagnosis. His score suggests that his depression is severe.

198. ICD-10 F43.1 Post Traumatic Stress Disorder

199. This is defined within ICD-10 as follows:

200. "*Post-traumatic stress disorder. This arises as a delayed and/ or protracted response to a stressful event or situation (either short – or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime)…*"

201. In my opinion, **D687** also suffers from Post-Traumatic Stress Disorder. This would be indicated by his past history of experiencing a number of highly traumatic events that would be likely to cause pervasive distress in almost anyone that has experienced them, in particular, his previous reports of experiencing trauma during his childhood whereby he was subjected to physical abuse by his family members who he now suspects were not his biological family and that he was taken from his real parents as a young child. He has reported being taken into foster care and that his foster mother was an alcoholic and also

abused him. He also alleges being verbally, racially and physically abused during his detention at Brook House IRC. Clinically, he presented as an individual suffering from severe symptoms of PTSD that have worsened since his recent imprisonment. He has memories of the trauma that he reports that keep entering his mind which he finds distressing. He has also experienced images popping into his mind of the trauma that he reports, consistent with flashbacks which are distressing and intrusive. He has also experienced bad dreams and nightmares which prevent him from sleeping and occur on a daily basis. D687 has become jumpy and is easily startled by loud sounds or noises. He remains very tense. He has also become avoidant and does not like talking about the events that he reports and dislikes being reminded about his past traumatic experiences. He continues to have strong and distressing emotions related to the trauma that he reports, which he has not been able to resolve. He said that he fears being grabbed and kidnapped and that he often saw people shooting each other in Somalia. Although D687 was experiencing symptoms of PTSD during his detention at Brook House, I would need to further examine his records before I could provide my opinion on whether he likely satisfied the diagnostic criteria for PTSD at that time. Given it is outside the scope of this report focusing on current capacity, I will not deal with it further here but am willing to do so in a further report, if required.

202. D687 has also suffered from a range of anxiety-related symptoms including feeling anxious and worried all the time. He described feeling his heart racing at times and said that he feels anxious when speaking to other people. He has also suffered from shaking and sweating and shouts when distressed. He told me that he also experiences shortness of breath at times when feeling anxious and has had panic attacks.

203. ***Please indicate the treatment he is currently receiving and any treatment or investigations which you would recommend. Please give your prognosis.***

204. In my opinion, D687 requires ongoing treatment of his mental health problems in the UK. In my opinion, his depression needs to be treated in