Witness name: Husein Oozeerally

Statement no: 1

Dated:

Brook House Inquiry

DRAFT Witness statement of Husein Oozeerally

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 14/11/2021. I have been authorised by DoctorPA Ltd (42 Kew Court Richmond Road, Kingston Upon Thames, Surrey, KT2 5BF) to provide this witness statement.

I, **Husein Oozeerally**, (of DPA will say as follows: -

Introduction

I am Dr Husein Oozeerally. I am a General Practitioner (Medical Doctor) that has worked in Immigration Healthcare in this capacity since 2013 and at Gatwick IRC since December 2014 until the present day.

Background

Dr Husein Oozeerally DoB DPA

GMC DPA

Qualifications

Diploma in Clinical Dermatology (Distinction)	QMUL	2016
MRCGP	RCGP	2012
MRCPCH	RCPCH	2008
MB ChB	Leeds University	2004
BSc Medical Microbiology (2:1)	UCL	2002
RCGP Part 1 Drug and Substance Misuse		2013
RCGP Part 2 Substance Misuse		2018

Medical Roles to date

Pre-Registration House Officer		2004-2005
Paediatrics	ST1-3	2006-2009
GP VTS training		2009-2012

Since 2012, I have worked as a portfolio GP (various roles and positions)

I was employed initially by Saxonbrook Surgery who were at the time subcontracted by G4S Healthcare to provide the GP provision at Gatwick IRC. DoctorPA Ltd took over from Saxonbrook in April 2017. I am a Co-director of DoctorPA Ltd (Company number 09356355). I worked 2-3 days a week at Gatwick IRC under Saxenbrook and continued 3-4 days a week from April 2017.

Application Process

1. There was no formal application process. I was working as a locum GP and had experience at Harmondsworth IRC. I did come to the site and have a brief informal interview and induction. The induction involved an introduction to the team, the role of the GP and the layout of the day as well as orientation of the site and IT system.

Culture

2. I don't think there was a particular culture of behaviour of the staff as a whole on the site or even within healthcare. Within healthcare, which is the environment I worked within, the environment was challenging. The challenge was the balance of delivering healthcare to patients who were in an interim state in terms of their Home Office situations. This could, in instances, impact on behaviour of some patients and/or presentations and management of illness (mental or physical).

3. I can say that staff morale was low in the period immediately after the Relevant period.

4. From a healthcare perspective, I do not think attitudes towards residents at the centre changed before, during and after the Relevant Period. I cannot comment on relationships outside of healthcare, as this is outside my sphere of knowledge and I did not observe any quantifiable changes.

5. I did not have any particular concerns about values and culture of G4S at the time in relation to:

    a. the general treatment of individuals who were detained at Brook House;
    b. the management of individuals with physical health conditions;
    c. the management of individuals with mental health conditions;
    d. the management of individuals who could be considered vulnerable;
    e. the management of individuals with substance misuse issues;
    f. the protection of specific individuals from the type of abuse seen on the Panorama programme.

6. I was supported by G4S Healthcare in safeguarding decisions. I was not involved in every aspect of safeguarding but was involved in both informal and formal discussions about complex patients where there were concerns raised to me about vulnerability and clinical decisions. This could take the form of multidisciplinary team involving nursing staff, mental health staff and substance misuse (and myself).

7. I do not recall any occasions where a member of healthcare staff raised concerns about the treatment of individuals (either individuals or collectively), whether informally or as a "whistleblower".

Oversight

8. In relation to the various bodies set out below, their involvement at Brook House, and the nature of any interaction I had with them, I would say as follows –

    a. The Independent Monitoring Board (IMB) – and independent body who have complete access to IRC and give a voice to the residents to ensure wellbeing and safeguarding. I did not have any direct engagement with IMB.
    b. The Gatwick Detainees Welfare Group (GDWG) – I am unable to comment. I did not have any direct engagement with them.
    c. Medical Justice – non-Government group who assist residents in their immigration and detention cases and issues. I did not have any direct engagement with them.
    d. Bail for Immigration Detainees (BID) – non-Government group who assist residents in their immigration and detention cases and issues. I did not have any direct engagement with them.

General Training

9. Before and during my period of work at Gatwick IRC, I had attended informal training and gained experience in the immigration healthcare environment. In addition to General Medical training and appraisal, I undertook courses such as RCGP Substance Misuse Part 1. This is a course run by the Royal College of GPs and provides online and day course attendance on misuse of illicit substances and treatment strategies.

10. I feel I was suitably qualified and experienced to undertake my role as GP in Gatwick IRC.

11. In order to fulfil the role in healthcare at Brook House, I would say that for Healthcare professionals new to the environment, I would recommend training and supervision, and ongoing support in the processes of ACDT, Rule 35, Food and Fluid refusal and Substance Misuse.

12. In terms of improvement I would say that DoctorPA Ltd already ensures clinicians receive the appropriate training and support. This is undertaken with a formal induction of site and process, including Rule 35 training (which I conduct). There is ongoing appraisal and supervision, as well as support provided. I am a Co-director of DoctorPA Ltd and facilitate this training. This relates to DoctorPA Ltd provision now but the clinicians during the relevant period were sufficiently experienced in Rule 35 process. There was no formal training by DoctorPA Ltd during the period in question. The current training involves a session involving formal description of Rule 35 and introduction to appropriate DSO and paperwork. We also undertake a number of Rule 35 appointment, supervise the doctor undertaking Rule 35 appointment, and guide them in the preparation of the document to the Home Office (through visualisation of real Rule 35s documents undertaken). The supervision and guidance will continue until the clinician until the clinician feels able and prepared

13. DoctorPA Ltd, as funded by G4S, did ensure that I undertook further training in substance misuse through the Royal College of GPs. I completed this in 2018. I am unaware of refresher or additional training made available to me prior to this date.

14. I am not aware that I attended any of the training courses provided by G4S to its staff but policies were made available to me. I do not have a list of titles of the policies but these were in the healthcare office and also on the G4S intranet.

15. I set out below the training G4S offered to its staff –

    a. Control and restraint (C&R) / use of force on individuals (including both planned and unplanned use of force). Please refer to the Violence Reduction Strategy (CJS000721);
    b. Rule 35 assessments and reports; The management of individuals at risk of self-harm or suicide and the ACDT process including the threshold for opening an ACDT document, the management of individuals on an ACDT document and how to complete the documentation. Please refer to the following documents / policies: (i) Suicide Prevention and Self-harm Management (CJS006380); (ii) Safeguarding Policy (CJS006379); (iii) Guidance for staff managing detainees on Constant Observations (CJS006378); (iv) Management of Adults at Risk in Immigration Detention (CJS000731); (v) Introduction to Safer Custody, Gatwick IRC's Caring for Detainees at Risk (CJS000052); (vi) Enhanced Mental Health Training, Gatwick IRCs Caring for Detainees at Risk (CJS000020); (vii) The management of individuals with substance misuse issues. Please refer to the Drug and Alcohol Strategy (CJS006083); (viii) Any other specific healthcare training.

16. I can confirm that I do not recall from the above list, during the specified time period, any training on the individual area during my employment at Brook House other than external training through RCGP (for example RCGP Part 1 Substance Misuse).

17. I do not believe I attended Health Quality meetings, but the minutes would indicate if I was in attendance. If I was not invited, then I would not have received updates regarding outcome. I am unable to recall receiving updates.

Staff Induction

18. I did not receive any formal induction, to the best of my recollection with the exception of the initial induction previously stipulated. I cannot therefore comment on any issues relating to the Brook House staff induction process.

Management of healthcare staff

19. As an organisation and subcontractor, if I had concerns, I would report any concerns directly to Sandra Calver, who was Head of Healthcare. During the working day, I would work with Healthcare assistants, Nursing (Physical and Mental) and administrative staff. I would encounter Officers working in the centre also interact with Home Office staff if appropriate.

20. I was line manager to Dr Catherine Eades, General Practitioner.

21. I had and continue to have a good relationship with Sandra Calver, and her team which I believe included Michael Wells and Jacintha Dix. They were available directly on site within healthcare daily and also by email or phone on weekends.

22. Sandra and her team remained supportive and have a good understanding of the environment and have good relationships with the relevant stakeholders at Gatwick IRC. I have had a good experience as a whole.

23. I had a good working relationship and experience with all healthcare professionals at Gatwick IRC Health.

24. I was not involved in clinical supervision of healthcare staff during the Relevant Period.

25. I did not encounter any problems with line management or clinical supervision.

26. I have no additional comments to make regarding improvements or the disciplinary and grievance process. I was not involved in any disciplinary investigation in the period outlined. I am not aware that I was involved in any grievance investigation in the period outlined.

Staffing

27. I am unable to comment on the staffing arrangements and numbers in healthcare at Brook House with any accuracy during the period mentioned.

28. The staffing levels appeared adequate, in my opinion. They were available to undertake the duties that we required of them as doctors.

29. I am unable to comment on the proportion of permanent healthcare staff to agency staff.

30. Agency staff were experienced in working in detention centres or a custodial environment generally. They were familiar with the systems and procedures in place at Brook House. I cannot comment on their induction. In any case, there were, from my recollection, regular locums to Gatwick IRC.

31. The number of agency staff did not affect the provision of healthcare to individuals.

32. I do not recall any shortages on any particular day. I believe to the best of my knowledge that the core aspects of the service from healthcare remained intact and do not recall any safety concerns.

33. I do not recall any healthcare staff shortages.

34. I do not feel I can comment on staffing levels and requirements in general or contractual obligations. It is true that there was restricted dental provision and perhaps a need for more mental health services. I cannot comment in particular on whether during the referenced period, I had additional concerns.

35. I am unable to comment on the staffing levels of the activities team.

36. With regard to day to day working with the detention team I would say that it is a challenging environment with multiple contributary aspects. I witnessed examples of good regard to welfare of the detained and also recall discussions of frustrations by staff (though cannot recall any specific examples).

37. I am unable to comment on the effectiveness of involvement of the detention team in use of force incidents.

38. I generally recall that detention staff would raise concerns to the healthcare team about the detained with ongoing medical issues. When an ACDT was opened, GPs would complete the form and also discuss with centre staff. Healthcare staff including GPs would also communicate concerns to Home Office through Rule 35 or Part C.

39. My interaction with detention staff was limited to escorting me to the cells on E wing and also those attending healthcare department. I had no specific concerns at the time relating to the attitude of detention staff towards detained persons based on this.

40. I did not experience any problems with the relationship between healthcare and detention staff.

Relationship with the Home Office

41. I had a good working relationship with members of the Home Office. They were accessible and engaged well with me, receptive to recommendations and clinical opinions/recommendations. I don't think it is possible to comment on the opinions relating to balance when I do not have oversight of the factors they are considering. I did not experience any problems with the relationship between healthcare staff and the Home Office.

42. We are not involved in New Reception Screening as GPs. All new reception residents are offered appointments to see the GP, with particular emphasis on those with those on medication and those with conditions which require healthcare involvement (such as referrals or management plans).

Healthcare Facilities and Equipment

43. Primary care is accessed within the centre through a locked door opposite the lifts. The door opens on to small waiting room. There are four rooms accessible from the waiting room (The GP room, the Nurse assessment room, the pharmacy and the Healthcare management room). The GP room has a desk and chair, computer and examination couch, and hand washing facilities. Equipment for use (such as stethoscope, saturation probe and blood pressure monitor) is available for the GP, as well as one use only equipment (but it is expected that the GP brings their own equipment that has been checked and serviced each year.

44. I am unable to comment on mental health services.

45. Healthcare had the physical resources and equipment to deal with the health conditions with which individuals presented.

46. There were no issues that I was aware of relating to either the physical environment regarding the provision of healthcare to individuals or relating to equipment.

Access to healthcare

47. It is my understanding that during the period in question, residents were able to access healthcare services initially at new reception by the nurse, and then daily for routine issues through a nurse triage clinic (open access, without having to book). In the event that there was an emergency, Hotel 1 (a Nurse has a radio daily with this Call sign of "hotel one") would be called to access a patient at the required location outside of healthcare. I believe Mental Health was also available 7 days a week and Primary care would refer into this team who were able to manage their patient list accordingly, assessing patients according to urgency. It would be the Mental Health team that escalate concerns to the GP or the psychiatrist. We would also have a weekly multi-disciplinary team to discuss complex patients, as well as daily handover. I do not recall any names, with sufficient accuracy, who attended daily handover during this time.

48. I do not think there was, nor am I aware of any delay to a patient accessing healthcare in a time and condition appropriate manner. I do not recall any other issues.

Detained Persons

49. The most significant health problems for detained persons population related to the use of illicit drugs (such as spice/NPS) and mental health. I am unable to specify particular examples during the relevant period and I am sure we managed conditions of hypertension and diabetes. The greatest challenges faced would be managing a range of patients presenting with nonspecific anxiety-related symptoms, individuals who wished to frustrate their removal with mismanagement of their health conditions (such as not taking medications), individuals who displayed maladaptive coping strategies (such as self-harming).

50. The challenges facing healthcare staff I think relate to access to interpreters, consultations with interpreters can be an issue. Residents' perception that healthcare colludes with Home Office against them can also be problems. It is also challenging dealing with patients with anxiety, behaviours and maladaptive coping strategies that relate entirely to being detained, detained without fixed sentences, and detained whilst anticipating an outcome that it not wanted.

51. We use an interpreter service. In the most there will be access to an interpreter. On occasion, there may be a delay (on >10 minutes) in getting the interpreter, a challenging interpreter, an inability to get a rare language (particularly at the time required), or the availability of an interpreter of the same language but a different tribe/community who the resident is hostile towards.

52. Problems would arise if there was an inability to get an interpreter during the GP consultation, it would delay the consultation. Sometimes we might seek alternative means such as a friend translating or an officer, but the patient would always be offered an alternative appointment, from my recollection, to address the issue.
53. I am not involved in the development of the Supported Living Plan ("SLP"). The SLP is the remit of the Nursing team. However an SLP is required where a resident has a mental and/or physical health condition that requires additional input from the healthcare team and/or associated adjustments/input from the Site.

54. If there were detainee SLP complaints it would be the role of healthcare to identify and formulate collaboratively with the site the SLP, and also ensure the implementation occurs through regular review.

55. If an individual had a complaint about healthcare, G4S has a specific policy for complaints and process. I would advise that they are contacted to get a copy and/or summary of this.

56. I was not involved in the complaints process as this was managed through the G4S healthcare team on site. I do not believe any complaints against me were upheld. I do not recall and am unaware of the details of complaints that were not upheld.

E Wing

57. There are 2 healthcare observations in E wing and at the end of E wing there is a Care and Separation Unit ("CSU"). In particular reference to E wing, individuals would reside here is there was issues of safety for the patient or others in relation to the patient. From a healthcare perspective, individuals were in E wing, who may not be able to access the appropriate care or suffered with issues regarding to substance misuse (alcohol or drugs) and were being stabilised or required isolation (example, suspected TB). I do not have knowledge regarding how healthcare staff specifically treated or monitored the patients on E wing.

58. The decision to move an individual to the CSU was not a healthcare or GP decision and I am not aware of the criteria.

59. All CSU patients will be seen by a GP and/or member of healthcare daily (7 days a week). The purpose of the review was to enable access to healthcare and manage the acute medical issues, for the residents who would not be able to attend healthcare otherwise.

Medication

60. Medication is only given in possession after a risk assessment which is regularly reviewed. There is an assessment undertaken by Nursing team which includes issues of understanding, diversion

and mental health (among others) before a decision is made. Risk assessment is a continuous process, as risk is a moving goal post.

61. If an individual was prescribed medication that could not remain in their possession, from the perspective of a GP, the medication is re-charted on the SystemOne (the Medical records software) as not in-possession. Healthcare will then require the medication to be returned to pharmacy and then dispensed at regular medication times from pharmacy by a qualified member of the healthcare staff.

62. Considerations that are additionally required in a secure environment, in relation to medication, are diversion (by the subject or through bullying), compliance and the types of medication prescribed.

63. Healthcare (pharmacy, nursing team and other healthcare prescribers) liaise with site to identify better or safe prescriber practices. I do not have any particular suggestions for improvement at this moment.

Drug / alcohol misuse

64. The Nursing team (including healthcare assistants) identify those requiring intervention through induction questioning (from a template) at new reception. For further assessment, a Urine Drug Test is undertaken. The GP prescriber will then prescribe appropriate medication. The Healthcare team will follow appropriate policy and the resident will be monitored at an appropriate location and with clinically appropriate observations. A referral will also be undertaken to the IDTS psychosocial team (FORWARD trust, I believe).

65. Treatments available for individuals identified with substance misuse issues include Opiate Substitution Treatment, Alcohol detoxification and Benzodiazepine detoxification, as well as psychosocial interventions (which were provided by the Forward trust). The exact scope of service delivered by FORWARD trust is best explored with them.

66. In my view, the services and treatment available for individuals with substance misuse issues were adequate.

67. I cannot specifically recall the issues regarding substance misuse at the time but I believe there were a number of incidents of drug seeking behaviour and Psychoactive substances (illicitly entering the centre). In general, the Healthcare team would be dealing with a maximum of 10 patients requiring OST (Opiate Substitution Therapy) though there would be a larger cohort who may have been engaged with Psychosocial services.

68. In relation to Healthcare's role in the management of individuals using drugs and alcohol it would be involved in the general mental and physical health, as well as the monitoring of symptoms and prescribing for substance misuse. The GP would also have a weekly MDT (team meeting) with the Psychosocial team to develop a clear management plan. There were no other attendee to the meeting. The GP would review the patients on OST (Opiate Substitution Team) at the initial prescription, Day 5 and also day 14 as a minimum. In regard to alcohol detoxification, observations and engagement would be more frequent.

69. The Nursing team would attend and make assessment of those with acute intoxification and there were G4S Healthcare policies in place (I believe) to guide the management of such individuals.

The nature of the intervention depended on the presentation. I had no concerns about the appropriateness of healthcare staff's management of individuals who were intoxicated. I had no concerns about the appropriateness of detention staff management of individuals who were intoxicated.

Mental Health

70. As a GP, I was involved in many patients who suffered with mental health issues from depression to acute psychosis. Some individuals were detained with existing conditions, and other new diagnosis. Some with severe presentations and others with mild symptoms. Some remained stable in detentions and some got worse in detention, as a consequence of detention or as a consequence of their situation (life experiences or immigration factors). I worked closely with mental health team and psychiatrist to identify those who would benefit from intervention. In some cases, we referred them to secondary care services (secure mental health hospital) for further observation and/or treatment. We would inform and collaborate with the Home Office to identify those who were not fit for detention or who would not be suitable for removal due to severity of illness. Healthcare would manage the patients whilst they were in the care of Brook House until their release or removal and in some instances I understand the ongoing care into the community. I cannot recall particular examples.

71. I had no concerns about the appropriateness of healthcare staff's management of individuals who suffered from mental health conditions or about the appropriateness of detention staff management of individuals who suffered from mental health conditions. If I had concerns I would have raised them to the Healthcare Manager and to the Centre Director (who I had always found to be helpful in regards to Detainee welfare).

72. I am involved in Rule 35. During the period mentioned, I recollect GPs were doing 2-3 a day and were provided with adequate time to undertake them. I am and I was quite experienced in undertaking the Rule 35 assessment, having working in IRC for more than 2 years prior. A Rule 35 from assessment to completion of the document could take from 30 minutes to 1 hour.

73. The purpose of the Rule 35 is to identify those that are vulnerable and are not suitable by means of this vulnerability to detention.

74. The requirement for a Rule 35 assessment is undertaken at reception through focussed questioning (example; are you a victim of torture?) and remains a continual process throughout the stay in detention. The requirement may be following Centre or Healthcare screening, observations or interactions or at the request of the Resident/Advocate or in the most, at the request of the solicitor.

75. The GP will complete the Rule 35 template (with interpreter, as appropriate) through a mixture of open but focussed questioning, in the privacy of a clinic room. It is explained to the resident the purpose of the Rule 35. The template from the Rule 35 is completed and submitted to the Home Office, within hours and a copy given to the patient.

76. From a Rule 35 perspective, the GP is aiming to identify vulnerability. The suitability of detention is based on current presentation and the effect detention is having or may have on physical or mental health. This may be based also on historical information and previous detention.

77. I would understand that the Home Office would be responsible for ensuring compliance with clinical standards and the effective implementation of the Rules 33-35 of the Detention Centre Rules (DCR) safeguards. We as clinicians have set guidance and standards. We have tried to implement our own benchmarks to ensure quality control, based on information gathering rather than outcomes (which remains the remit of the Home Office). During the relevant period, there

were DSO guidance available on the internet, and all clinician working at the centre were aware of these (to the best of my knowledge).

78. The greatest challenge in carrying out Rule 35 assessments is that there has been a constantly changing landscape of the definition of torture and an increasingly broad definition of vulnerability. The effect of this, whilst outwardly suiting the purpose of advocacy groups, has meant an inevitable misuse of the Rule 35 and Adults at Risk policy, and delays in the process. We have discussed with the Home Office about a change in strategy in this respect to resolve this but without success. I was involved in discussion with Ian Cheeseman and Terry Gibbs at the Home Office. I do not have the exact dates of these discussions.

79. The process of the Rule 35 has become diluted and rather than exclusively identifying those at risk in detention and effecting change, has been a tool used by advocacy groups (who threaten legal action at times) in the asylum claims.

80. I have raised concerns relating to this to the Home Office. I have also formed part of the ICIBI and tried to work with advocacy groups to remedy the issue. There has been little success. THE ICIBI was formed as an independent body to hold Home Office to account following recommendations from the Shaw Report. I have not observed any significant changes in my working experience.

ACDT and self-harm risk management

81. My role as a GP is to understand how to open an ACDT if I have concerns about the welfare of an individual, particularly in term of mental health and issues of self-harm or suicide. I also understand that I will document within the ACDT document if I have encounters with the individual who has an open ACDT.

82. Identification and assessment of individuals who were at risk of self-harm or suicide is a continuous process based on information from the site staff and clinical encounters with the resident. It may occur after an incident (of self-harm) or following a statement from the subject.

83. All members of staff have a responsibility to identify risk including healthcare staff.

84. Healthcare staff may be involved in opening an ACDT, conducting welfare checks and also attend ACDT reviews (to facilitate multidisciplinary assessment).

85. I had no concerns about the appropriateness of healthcare staff's management of individuals who were at risk of self-harm or suicide or did I have any concerns about the appropriateness of detention staff management of individuals who were at risk of self-harm or suicide.

ACDT

86. The purpose of the ACDT document is to provide a uniform and organised approach to managing individuals who are at risk of self-harm or suicide, bringing together the relevant stakeholders, coordinate approach and ensure regular review and team strategy.

87. There is a low threshold to opening an ACDT. From the perspective of a GP, an ACDT is open when risk meets a threshold. It involves the documenting in the ACDT, the details why it is being opened and by whom. Oscar 1 is then informed and the patient remains in company until reviewed by Oscar 1 (Senior responsible Site Officer).

88. The decision as to how the individual is managed is undertaken by Site (DCM etc) but involves risk assessment, engagement and regular review.

89. The GP is not involved in the review process for individuals with an open ACDT document.

90. It is a decision for the teams involved as to when an ACDT document be closed in relation to an individual, but this would be when the risk of self-harm or suicide no longer exists.

91. It is outside the scope of my knowledge as to how an ACDT may be challenged.

92. Healthcare would be involved in opening ACDTs and be aware of all those with an open ACDT. They would also be involved (particularly the mental health team) in the regular reviews.

93. Any problems relating to the process of managing individuals on ACDT documents are outside the scope of my knowledge. I am unable to comment regarding any possible improvement that could be made.

94. I was involved in the Multi-Disciplinary Team ("MDT") meetings regularly. In such meetings we discussed complex patients and challenging cases which would benefit from a coordinated approach in terms of management.

95. I am unaware of Safer Community Meetings and Adults at Risk (AAR) Meetings held in Brook House which were attended by detention staff. I was not invited to attend.
96. In relation to mechanisms of support or counselling to individuals who had witnessed a violent or distressing event at Brook House I would say that there were weekly group psychological drop-in sessions and also Residents were about to attend healthcare or engage with the mental health team.

Food and Fluid Refusal

97. In relation to assessing an individual who was refusing food or fluids, the healthcare team would (with consent) do regular observations (heart rate, blood pressure, weight, blood tests etc) during the period of food and fluid refusal. The Healthcare team, including the GP would monitor the patients' mental and physical health, assessing general health in terms of the effects of refusal but also the possible risk of refeeding. We would also discuss the case as part of MDT and liaise with the Home Office about the welfare of the patient, and quantifying risk. The purpose of a multidisciplinary approach to ensure good communication and a joint strategy. Healthcare would communicate directly with the Home Office (this is the remit of the Healthcare Manager) through email or phone to a specified person or through a document called the Part C. The Broad outcomes that I would observe would be Release or Detention (with plan to expedite case progress).

98. The documentation of an assessment would be put in the medical records from a GP perspective.

99. I have significant experience in managing individuals who refuse food +/- fluid in the secure setting, particularly IRCs. It is a very challenging situation and whilst there are common themes, each situation and individual remain unique, as must each approach. The most common situation is a food and fluid refusal as a means of protest from detention and from removal. In a significant amount of these cases, the patient will refuse assessment and intervention.

100. I did not have any concerns about the appropriateness of management. We managed the patients in accordance with best practice. The greatest challenge remains the patient's choice to refuse (which must be respected) and the patient's failure to engage. There are policies now which help guide Management of Residents on food and fluid refusal but prior to this monitoring

with blood tests, and basic observations with the biggest challenge surrounding the risk of refeeding syndrome.

Use of Force

101. The GP may be asked to comment if it is appropriate to use force in the case of certain medical conditions by the Site staff.

102. The circumstances when is it permitted to use force on an individual is not an area that I am expected to have knowledge in. I would expect that the use of force decision, is a balance of factors based on the individual, the situation and the intended outcome.

103. The records required to be completed by healthcare staff following a use of force against an individual is not something that is not applicable to me.

104. I am not involved in any follow up carried out by healthcare staff on a detained person following a use of force unless specifically asked by the nursing team to assess the patient.

105. I have never been involved in the use of force on an individual.

106. I have witnessed the use of force on residents. I have been there peripherally to support the nursing team member if asked. That support and my intervention has not been required.

107. I have no concerns about the appropriateness of the use of force on the individual.

108. I worked in Healthcare and whilst I was aware of an individual called Callum Tulley, I did not have any interaction with him (other than greetings).

109. I do not believe I appear in the footage of the Panorama programme.

110. After the programme there was a tangible reduction in morale and increased anxiety amongst staff (as disciplinary action was taken) and there was a perception the programme did not present the IRC and staff accurately.

111. Issues regarding age dispute of detainees do happen in IRC environments and there are processes in place to manage this (external authorities). The process of age dispute is a matter addressed by the Home Office Authorities and not healthcare.

112. Following the Panorama programme there was a number of discussions with the healthcare staff about "speaking out" if it was observed actions and behaviour contrary to our values. There was also a number of site staff that no longer work at the centre. The loss of experienced staff meant it felt un-safer on the wings (outside of healthcare).

Specific Individuals

113. I had interactions with the many Site staff on a daily basis but could not really identify individuals by name. During my interactions, I did not observe any behaviour or dialogue that I deemed at the time to be inappropriate.

114. I did work with Nurse Jo Buss. Throughout the time I worked with Jo Buss, I found her to be extremely caring and conscientious. She had a particular focus on safeguarding and patient welfare.

Suggestions for improvements

115. In relation to what could be changed or improved at Brook House I think there needs to be review of the Rule 35 and Adult at risk policy. And I also feel there needs to a reduction in the stay within IRCs (1 week maximum). Residents may also benefit from a certainty of outcome (whether the outcome is one that is deemed favourable or not). More psychological services to provide support would also be beneficial which would include counsellors and more talking therapy.

Any other Concerns

116. I think all the topics relating to the culture of G4S at Brook House and the treatment of detained persons are covered sufficiently in the above questions.

117. The matters I have written about are according to my own knowledge.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signature

.....

HUSEIN OOZEERALLY

30/11/2021

.....

DATED