REPORT

Brook House Inquiry

Report of	Dr James Hard MBBS FRCGP
Dated	November 2021
Specialist field	I hold the degree of MBBS (London) [1998] and am a Fellow of the Royal College of General Practitioners. As a GP, I have developed further special interests in substance misuse and prison medicine. I have worked in several English and Welsh (public and private sector) prisons and have over 15 years of experience. I am the Chair of Royal College of **GP's** Secure Environments Group. I am an associate advisor to the Parliamentary and Health Service Ombudsman and provide clinical advice across the general practice, substance misuse and prison domains. I have been a clinical reviewer commissioned by NHS England to assist the Prison and Probation Ombudsman with Death in Custody investigations. I contributed to the NICE Guideline Development Group for the Physical Health of People in Prisons.
Instructed by	Ellis Pinnell, Solicitor to the Brook House Inquiry
For	The Brook House Inquiry
Subject matter	I have been asked to assist the Brook House Inquiry in order to provide an independent expert report opinion in connection with the medical and clinical care issues within Brook House Immigration Removal Centre

Dr James Jesse Hard

DPA

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1. Introduction

1.1. The writer

I am Dr James Jesse Hard and I am an expert within the field of General Practice with special interests in prison medicine and substance misuse. I have over fifteen years of experience as a general practitioner. I am the Chair of the Royal College of GPs Secure Environments Group. Full details of my qualifications and experience entitling me to give expert evidence are listed in Appendix 1.

2. Summary background

The following has been italicised to reflect that it has been copied directly from the Letter of Instruction:

- *On 5 November 2019 the Home Secretary established the Brook House Inquiry to investigate the decisions, actions and circumstances surrounding the mistreatment of detainees at Brook House Immigration Removal Centre (IRC) shown in the BBC Panorama programme "Under-Cover: Britain's Immigration Secrets", aired on 04 September 2017. It is an independent statutory inquiry under the Inquiries Act 2005.*
- *The Inquiry's Terms of Reference require it to consider and report upon a wide range of issues which include:*

  […]
- *Whether any clinical care issues caused or contributed to any identified mistreatment.*
- *Whether any changes to clinical care would help to prevent a recurrence of any identified mistreatment.*

  […]
- *As well as the full version of the Terms of Reference, the Inquiry's website also contains the Chair's determination on scope, within which the Chair sets out a list of questions that will be explored during the course of the Inquiry. These include at paragraph 3:*

  […]
- *g. The assessment of vulnerability (including the process referred to as 'Rule 35' and the Adults at Risk policy)*
- *h. The extent and suitability of the specialist mental health provision*

  […]
- *p. Management of healthcare staff*

3. Issues to be addressed

I have set out the following areas for consideration as per the Letter of Instruction dated 16 February 2021:

Areas for consideration

3.1. The management of healthcare staff, the relationship between healthcare and other entities in Brook House, whether appropriately qualified clinicians were employed, and whether they received adequate training.

3.2. The effectiveness of assessing vulnerability at Brook House in the relevant period. In particular the operation of Rules 34 and 35 of the Detention Centre Rules 2001, and the efficacy and use of the Adults at Risk policy.

3.3. The extent and suitability of the health provision, particularly mental health provision, medication and prescription management, the clinical management of self-harm and food and fluid refusal, and the relevance, if any, of substance misuse in the treatment of detainees.

3.4. Examination of the extent to which the mental health issues or needs of detainees played, or may have played, a part in the treatment to which those detainees were subjected.

3.5. Identification of areas for improvement of practices, policies, procedures, oversight and systems (of the Home Office and its contractors) that could be put in place in future to identify and act upon any identified shortcomings.

4. Summary of my conclusions

This report will show that having reviewed the available documentary evidence provided to date, that during the relevant period:

4.1. In my opinion, the system for Rule 35 and Adults at Risk policy was inadequate and would benefit from a review in order to establish a more dynamic and efficient approach to detained persons considered to be at risk.

4.2. In my opinion, the systematic approach to the training and education of staff in a number of areas was inadequate. This was particularly relevant to the Use of Force, ACDT and Rule 35.

4.3. In my opinion, none of these features directly resulted in the mistreatment of detained persons. However, it is my view that as a result of the identified deficiencies in each of these areas, overall there was an inadequate system for the prevention of mistreatment of detained persons.

4.4. Based on the observations within this report and other relevant reading material, I have made a number of high-level recommendations in order to try and address some of these issues.

5. Investigation of the available material

I have inserted relevant entries from the available material and within these corrections have been made for minor typographical errors and the material in square brackets has been inserted to make the notes more readily comprehensible.

Rule 34

5.1. The Detention Centre Rules 2001 make specific provision under Rule 34[1] for detained persons to be offered *'Medical examination upon admission and thereafter'*. In particular, Rule 34 (1) specifies that:

- *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(7) or (10)) within 24 hours of his admission to the detention centre.*

5.2. The process for receiving a new arrival into Brook House during the Relevant Period was essentially comprised of two parts overseen by the security and medical staff and is outlined in the Detainee Reception and Departures policy[2].

5.3. The policy required that security staff provide an induction[3] and familiarisation to the unit, which takes account of any specific immediate needs the detained person may have, including but not limited to any reported medical needs and any reported risks of self-harm or suicide.

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[1] The Detention Centre Rules 2001, Rule 34 [https://www.legislation.gov.uk/uksi/2001/238/contents/made]
[2] CJS006045 – G4S Detainee Reception & Departures, Brook House Policies, last reviewed 4 May 2016
[3] CJS002174 – D1538 – Reception Induction record

5.4. The policy provided that medical staff would undertake a detailed '**first night**' medical screening which should be recorded on the electronic health record, SystmOne. This screening includes a variety of information, including but not limited to the detained **person's** past medical history, current medication requirements, known allergies to any medicines, upcoming hospital appointments, mental health history and history of self-harm and suicide. The member of staff should also undertake a series of physical observations including but not limited to a general observation of the detained person as well as pulse rate, blood pressure, height and weight.

Rule 35 (1), 35 (2) and 35 (3)

5.5. The Detention Centre Rules 2001 make specific provision under Rule 35[4] for detained persons who may be considered to be suffering from *'**special** illnesses and conditions (including torture **claims**)'*. Rule 35 (1) specifies that:

- *The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention*

5.6. Rule 35 (2):

- *The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.*

5.7. And Rule 35 (3):

- *The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.*

5.8. These three components of the UK Statutory Instrument are important mechanisms for ensuring that the specific attention is paid to detained persons who are considered to be at particular risk of deterioration within the confinement of a detained setting.

[4] The Detention Centre Rules 2001, Rule 35 [https://www.legislation.gov.uk/uksi/2001/238/contents/made]

5.9. In conjunction with these Rules, the Home Office has provided further detailed instructions within the Detention Services Order 08/2016 Management of Adults at Risk in Immigration Detention[5]. This Guidance, extant during the relevant period, further defined an Adult at Risk [page 5, paragraph 6] as being at risk:

- *if they declare that they are suffering from a condition, or have experienced a traumatic event (such as trafficking, torture or sexual violence), that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention; or*
- *if a case owner considering or reviewing detention becomes aware of medical or other professional evidence, or observational evidence, which indicates that an individual is suffering from a condition or has experienced a traumatic event (such as trafficking, torture or sexual violence), that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention. In these circumstances the individual will be considered as an adult at risk whether or not the individual has highlighted this themselves.*

5.10. This Guidance further specifies [page 6, paragraph 6] that:

- *On the basis of the available evidence, the Home Office case owner will reach a view on whether a particular individual should be regarded as being "at risk". If so, the presumption will be that the individual will not be detained.*

5.11. This Guidance further specifies [page 6, paragraphs 7 and 8] that:

[5] CJS000731 – Home Office Detention Services Order 08/2016 on Management of Adults at Risk In Immigration Detention, February 2017 v1.0.

- *7. There are a number of factors or experiences which will indicate that an individual may be particularly vulnerable to harm in detention. These include:*
  - *suffering from a mental health condition or impairment*
  - *having been a victim of torture*
  - *having been a victim of sexual or gender based violence, including female genital mutilation*
  - *having been a victim of human trafficking or modern slavery*
  - *suffering from post traumatic stress disorder (which may or may not be related to one of the above experiences)*
  - *being pregnant*
  - *suffering from a serious physical disability*
  - *suffering from other serious physical health conditions or illnesses*
  - *being aged 70 or over*
  - *being a transsexual or intersex person.*
- *8. It cannot be ruled out that there may be other, unforeseen, factors or experiences, that may render an individual particularly vulnerable to harm if they are placed in detention or remain in detention. In addition, the nature and severity of a condition, as well as the available evidence of a condition or traumatic event, can change over time and must be regularly assessed.*

Rule 35 (1)

Detention services order 08/2016 - Detention centre rule 35

Rule 35 (1) report - a detainee whose health is likely to be injuriously affected by continued detention or the conditions of detention

5.12. The policy requires the assessment of a detained person to be undertaken by a General Practitioner (GP) working within the Immigration Centre under Rule 35 (1), who would complete their report on Annex A of the Detention Services Order 08/2016. A copy of the completed report would be filed within the electronic health record (TPP's SystmOne) and a copy made available for the Home Office.

5.13. In line with the Instructions provided, I have reviewed a small number of Rule 35 (1) Annex A reports.

5.14. A blank Rule 35 (1) Annex A document is appended to this report at Appendix 4. Section 1 of the report allows for the provision of the detained person's details. Section 2 provides the authority on which the sharing of medical information is being provided.

5.15. Section 3 sets out the basis and context on which the Rule 35 (1) report is being provided:

- *I write in respect of the detainee named above in my capacity as an immigration removal centre medical practitioner. I hereby report that this detainee's health is likely to be injuriously affected by continued detention or the conditions of detention.*

5.16. Section 4 sets out the '**relevant** clinical **information**' for which the Rule 35 (1) report is being provided:

- *i) Why is the detainee's physical and/or mental health likely to be injuriously affected by continued detention or the conditions of detention? Please include as much detail as possible to aid in the consideration of this report. This must include an outline of the detainee's relevant physical and/or mental health condition(s).*

- *ii) What treatment is the detainee receiving? Is specialist input being provided, either within the IRC or as a hospital outpatient or inpatient?*
- *iii) In the case of mental health problems, has there been a detailed mental health assessment and, if so, carried out by whom and with what result/recommendation? If not, is an assessment scheduled to take place and, if so, when? Please attach the report of any assessment or give a brief overview.*

5.17. Section 5 sets out the '**Assessment**' for which the Rule 35 (1) report is being provided:

- *What impact is detention or the conditions of detention having (or likely to have) on the **detainee's** health and why? See above. On-going stress and the unstable nature of his cardiac condition put his health at risk.*
- *ii) Can remedial action be taken to minimise the risks to the **detainee's** health whilst in detention? If so, what action and in what timeframe?*
- *iii) If the risks to the **detainee's** health are not yet serious, are they assessed as likely to become so in a particular timeframe (ie in a matter of days or weeks, or only if detention continued for an appreciably longer period)?*
- *iv) How would release from detention affect the **detainee's** health? What alternative care and/or treatment might be available in the community that is not available in detention?*
- *v) Are there any special considerations that need to be taken into account if the detainee were to be released? Can the detainee travel independently to a release address?*

5.18. Within my review of the available material, I have only had access to a very small number of Rule 35 (1) Annex A reports[6][7] and am therefore unable to reliably comment broadly on

[6] CJS001024 – Rule 35 (1) Report re D1914 dated 17.7.17
[7] CJS000836 – Rule 35 (1) Report in relation to D24, dated 04/05/2017

the overall quality and consistency of these reports. However, of the two reports I have seen, the level of detail provided has been adequate. Furthermore, the determination being made by the GP within their assessment is clear and informative.

5.19. One of the significant differences between the Rule 35 (1) and Rule 35 (3) process is the **clinician's** consideration of the currency of the information available to them. Particularly, within the Rule 35 (3) Annex C section 4, the information being provided to the clinician relates to events in the distant past and the aim is to relate this information to (where relevant) the findings on examination of the detained person within section 5 of the report. Within section 6 of the report, the GP is then requested to reach a conclusion on the '**consistency**' of these two components of the report but then must also consider their views on the likely future impact of ongoing detention on the detained person.

5.20. In contrast, within the Rule 35 (1) Annex A section 3, the information being considered by the GP is recent in terms of both history and current presentation but also in terms of the acute impact on the detained person. This is relevant because the process for completion of the Rule 35 (1) reports appears more consistent with the '**medical model**' in terms of gathering a history and formulating a diagnosis and treatment plan.

Rule 35 (3)

Detention services order 8/2016 - Detention centre rule 35

Rule 35 (3) report - concerns that a detainee may have been a victim of torture

5.21. The policy requires the assessment of a detained person to be undertaken by a GP working within the Immigration Centre under Rule 35 (3), who would complete their report on Annex C of the Detention Services Order 08/2016[8]. A copy of the completed report would be filed within the electronic health record (**TPP's** SystmOne) and a copy made available for the Home Office as described below.

5.22. Paragraph 16 of the policy describes the process to be undertaken following arrival of a detained person who is considered to be an adult at risk:

> *16. The IRC supplier and onsite Home Office Immigration Enforcement (HOIE) team must prioritise their induction processes for adults at risk and ensure they are seen as soon as possible. Centre staff and healthcare staff must jointly undertake a centre-specific risk assessment of the detainee within 24 hours, which will include consideration of any medical concerns and risks, and be completed on an IS91 RA part C form. The IS91 RA part C form should be sent to DEPMU and the Home Office case owner simultaneously (using the dedicated casework generic inbox) and copied to the 'Detained AAR Part C' inbox. Upon receipt of the IS91 RA part C the case owner will enter the details on CID, updating the adults at risk special conditions flag,*

[8] CJS000731 – Home Office Detention Services Order 08/2016 on Management of Adults at Risk In Immigration Detention, February 2017 v1.0.

reviewing the decision to detain, if appropriate, in light of any new information that has emerged.

5.23. Paragraphs 18 and 19 of the policy describes the process to be undertaken should a detained person be identified as an adult at risk during their stay:

18. Any changes to the physical or mental health of a detainee, or a change in the nature or severity of their identified vulnerability, that may impact on the decision to detain must be notified to the Home Office case owner as a matter of urgency and within 24 hours to enable them to undertake a review of the appropriateness of the individual's continued detention at the earliest opportunity.

19. If a detainee informs centre staff that they are vulnerable, or if a member of IRC staff, IMB member or visitor (whether social or a member of an independent visitors group) believes the detainee to be at risk, the member of staff to whom the vulnerability has been raised should notify healthcare staff and the onsite HOIE team as soon as possible. This should include any wider vulnerabilities such as care support for a disabled detainee. In the case of a residential STHF the escort supplier must notify DEPMU. During office hours (Monday to Friday) the Home Office case owner must be notified within 6 hours, using an IS91 RA Part C form. The onsite healthcare team, or supplier staff where appropriate must raise an IS91 RA Part C, including the reference 'adult at risk' on the first line of the form, and submit this to DEPMU and copied to the Detained AAR Part C' inbox, with a copy also provided to the centre supplier and onsite HOIE team. DEPMU will then forward the IS91 RA Part C by email to the relevant

dedicated casework generic inbox. Upon receipt of the IS91 RA Part C, the case owner will open an 'adult at risk' special condition on CID as set out in paragraph 11.

5.24. In line with the Instructions provided, I have reviewed a tranche of seventy-six Rule 35 (3) Annex C reports in order to reach a view on the *'**effectiveness** of assessing vulnerability at Brook House in the relevant **period**… and the efficacy and use of the Adults at Risk **policy**'.*

5.25. A blank Rule 35 (3) Annex C document is appended to this report at Appendix 5. Section 1 of the report allows for the provision of the detained **person's** details. Section 2 provides the authority on which the sharing of medical information is being provided.

5.26. Section 3 sets out the basis and context on which the Rule 35 (3) report is being provided:

- *I have examined the detainee named above in my capacity as an immigration removal centre medical practitioner and hereby report that I have concerns that the detainee may have been a victim of torture. This is a factual report rather than a medico-legal one.*
- *I understand that torture in this context means: Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or*

incidental to lawful sanctions. I also understand that it includes such acts carried out by terrorist groups exploiting instability and civil war to hold territory.

5.27. Section 4 of the Rule 35 (3) report relates to the '**Detainee's account**', with the additional notes instructing the writer to:

- *Please provide details of the account given to you by the detainee of the alleged torture. In particular, please provide:*
  - *as much detail as possible about the detainee's explanation for the cause of each injury, scar or symptom (physical or psychological)*
  - *details of when, where, how, over what timeframe and why the torture is said to have happened, if possible.*

5.28. Section 5 of the Rule 35 (3) report relates to the '**Relevant** clinical observations and **findings**', with the additional notes instructing the writer to:

- *Please provide details of your objective clinical observations and findings. This should include:*
  - *details of all scarring or other physical marks, psychological symptoms, physical disability or impairment.*
  - *details of any medical or professional treatment/support that the detainee has received (including outside the UK) or is receiving and from whom.*
  - *any information in respect of previous or current physical or mental health problems which may be a result of having been tortured.*

5.29. Section 6 of the Rule 35 (3) report relates to the overall '**Assessment**', with the additional notes instructing the writer to:

- *Please set out your reasoned assessment of why, on the basis of the detainee's account together with your own examination and clinical findings, you are concerned that the detainee may have been a victim of torture. This should include your assessment of:*
  - *the consistency of any physical (eg scars) and/or psychological findings with the detainee's allegations, including any evidence to the contrary*
  - *whether there might be other plausible causes for the findings*
  - *the impact detention is having on the detainee and why, including the likely impact of ongoing detention*
- *If there are no physical or psychological findings to support the detainee's account, you must state why, in your professional assessment, you nevertheless have objective grounds for your concern.*

5.30. In order to reach a view on the efficacy of this policy, I have concentrated on the content provided within sections 4, 5 and 6 of the seventy-six Rule 35 (3) Annex C reports.

5.31. Broadly speaking, there appears to be significant variability within these in terms of quality and level of detail, whether that has been provided by the detained person and/or that which has been recorded by the GP.

5.32. It stands to reason that section 4 of the Rule 35 (3) report is consistent with the expected practice of any medically qualified doctor in terms of obtaining a ***'history'*** and that section 5 of the Rule 35 (3) report is consistent with the expected practice of any medically qualified doctor in terms of recording their findings ***'on examination'***. Together, these two components form the basis of the vast majority of clinical consultations.

5.33. As outlined above, section 6 of the Rule 35 (3) report requests that the GP reach a conclusion on whether *'... the detainee may have been a victim of **torture**'* but also '... *the impact detention is having on the detainee and why, including the likely impact of ongoing **detention**'*. It is at this point that two significant factors arise: firstly, the assessment of victims of torture is not covered within medical school education and therefore it is not reasonable to assume that all medical doctors would be competent in undertaking assessments of this nature. Furthermore, the assessment of torture is not contained within the routine vocational training schemes for GPs. Subsequently, this raises the question as to whether a GP possesses the appropriate skills, in the absence of any specific training, in order to reach a determination on a Rule 35 (3) report as to whether or not a detained person may or may not have been a victim of torture. It would be my expectation that the use of GPs without any form of training in the assessment and determination of suspected victims of torture, would lead to the potential for an inconsistent approach to the completion of the Rule 35 (3) Annex C report. Furthermore, it is my view that whilst the notes on the Annex C form are helpful and the Adults at Risk Policy[9] describes in more detail the *'**indicators** of risk within **detention**'*, these are not sufficiently informative to provide a reasonable level of assurance as to the overall competency of the writer and quality of a Rule 35 (3) report. In my view, this would be especially acute in the context where the GP who was being asked to write such a report was recently qualified and/or had little or no prior exposure to working in the Immigration Removal setting. This issue is further compounded by the request for the GP to consider the impact that detention is having and to attempt to reach a view on whether there is *likely* to be any deterioration. This is much more speculative in nature and in my view would in many cases require considerable

[9] CJS000731 – Home Office Detention Services Order 08/2016 on Management of Adults at Risk In Immigration Detention, February 2017 v1.0.

expertise in being able to judge whether or not a detained person could be particularly vulnerable to deterioration within the Immigration Removal setting or not. It is understandable that where the medical evidence provides a contemporaneous overview of the detained person and that during the period of observation, deterioration can be quantified, a GP will be in a more confident position to describe the effects on the detained person that detention is seen to be having. Where the GP has access to only a very brief snapshot or knowledge of the detained **person's** history, it stands to reason that the impact of detention would be much harder to predict.

5.34. I have reviewed the agenda[10] and PowerPoint training resource[11] in regard to Detention Centre Rule 35 provided to the GPs working in the Brook House Immigration Removal Centre. The presentation covered both Rule 35 (1) and Rule 35 (3) as well as the documentation of injuries.

5.35. I am not aware of any mandated level of qualification necessary for undertaking the work of a GP working in an Immigration Removal Centre other than to have achieved the Certificate of Completion of Training (CCT) as a GP or equivalent. I am not aware of any courses which are assessed on a formative or summative basis yielding a level of competency in the assessment of suspected victims of torture.

5.36. It is well recognised that workforce recruitment and retention of staff within secure settings is already disproportionately disadvantaged relative to the wider community given the general lack of awareness of this area of work combined with common misperceptions

[10] CJS007033 – Staff training agenda, 18/01/2016
[11] HOM002581 – Detention Centre Rule 35 slides for GP Training, dated 10/2015

about what is involved. Therefore, it is important to consider that introduction of mandatory training requirements could adversely impact on the ability of providers to adequately source and retain appropriately skilled practitioners to their workforce. Additionally, there are also potential cost implications for providers who would have to consider the development of specific training packages and/or investment in external courses with the potential for additional expenses of having to backfill staff whilst their practitioners undertake the necessary training.

5.37. It is my view that there are likely to be practitioners who have developed the appropriate level of skill and competency in completing Rule 35 (3) reports and are able to reach a determination of whether the detained person has been a victim of torture and/or met the threshold for an Adult at Risk through their length of service within the Immigration Removal setting and/or exposure to the number of reports completed. I would anticipate a GP to acquire a reasonable level of skill in this area if they were undertaking regular Rule 35 (3) reports and had accumulated experience over a 2-year period and written around 50 reports.

5.38. Below, I have reviewed four case studies of detained persons who have been assessed under Rule 35 (3) and one case assessed under Rule 35 (1) for this Inquiry. Within these case reviews, I have been provided with access to a wide number of documents pertaining to the different aspect of the **individual's** contact with the immigration detention system. I have set out each of these case studies in the subsequent sections below. However, having reviewed these documents, it is my view that there is no consistently applied process for feedback (and/or reflection) as an outcome from a completed Rule 35 (3) report. In my opinion, in the absence of any specific competency for this role, there ought to be a more

patent process for the analysis of the quality and consistency of these reports in order assist the GPs with a mechanism for improving their skill and attention to the details required to assist the Home Office in reaching their determination on the appropriateness of ongoing detention.

5.39. One of the themes arising from the case histories I have seen is that the Home Office may possess significant amount of information on the detained person that the GP would not have sight of when conducting their assessment of the Rule 35 (3) report. On the one hand, not having access to this information helps to ensure a reasonable level of independence and objectivity of the GP when completing their report, avoiding bias towards the detained person based on, for example, their past offending history. On the other hand, it is also understandable that having some form of insight or access to the relevant information would aid the GP in corroborating the account being provided to them, especially where there was evidence of any previous claims under Rule 35 (3) and other aspects relevant to their arrival in the UK.

5.40. From the **GP's** perspective, it is important to highlight that there is likely to be a conflict within the role they are providing within the Immigration Removal Centre setting. The primary role of the GP will, of course, be much broader than only the provision of Rule 35 (3) reports and otherwise comprises the delivery of '**equivalent**' general medical services to the detained persons. It is widely acknowledged that the basis for an appropriate therapeutic relationship with a patient is reliant on establishing trust with the patient in order to address and meet their physical and mental health needs. This should be no different in the Immigration Removal setting and as such would be largely consistent with the provision of '**equivalent**' primary care services available in the wider community.

5.41. However, the requirement and mechanism for the '**independent**' assessment for the Rule 35 (3) report does present an issue which could potentially undermine the relationship between the GP and the detained person. Detained persons may be motivated to impress upon the GP of their likelihood of having been a victim of torture as it is perceived that this could lead to their release from detention. Where the detained person has provided information for a Rule 35 (3) report and remains in detention, they may reach the conclusion that the GP does not believe their version of events or that the GP may be withholding a recommendation for the cessation of ongoing detention. The feedback provided within the Verita report and in particular the '**focus group**' notes[12,13] supports this experience.

5.42. The overall effect may ultimately be that this process undermines the quality of the relationships between the GPs and the detained persons, leading to levels of mistrust on one or both sides. Furthermore, it is important to consider whether there may be cases where it is difficult for the GP to hold both the role of GP providing general medical services and simultaneously provide a truly independent view in regard to ongoing detention as part of the Rule 35 (3) process. I have not been able to identify any policy or process that provides an alternative mechanism for the assessment of ongoing detention where this conflict may have arisen.

5.43. I have reviewed seventy-six[14] Rule 35 (3) reports in order to obtain a view on the level of adequacy of the reports being completed in Brook House and to consider their overall value

[12] VER000202 – 81 – Detainee focus group 2 notes – Copy
[13] VER000204 – 83 – Detainee focus group 1 notes – Copy
[14] Following closer inspection of the SystmOne records, I believe that at least two and up to four of the Rule 35 (3) reports were undertaken in Immigration Removal Centres other than Brook House [CJS002820, CJS002765, CJS003632, CJS003927]

in the wider context of the Home Office's decision-making process in regard to a person's ongoing detention.

5.44. The first observation to make is that there is no recognised benchmark (that I am aware of) against which the Rule 35 (3) reports could be readily assessed and by which there would be a means of reaching a conclusion as to the adequacy of each report. For this reason, I have developed a largely subjective method for reviewing the Rule 35 (3) reports in order to present my opinion to the Inquiry. Please see paragraph 5.58 below for an example of what I consider to be an adequate Rule 35 (3) report and paragraph 5.59 for an example of what I consider to be an inadequate report.

5.45. In reaching these conclusions, I firstly reviewed the level of detail contained in sections 4 and/or 5 of each Rule 35 (3) report and tried to reach a view as to whether the level of detail provided therein was adequate or not. In regard to the history being obtained for section 4 of the Rule 35 (3) report, it would be a general rule of thumb for the GP to record as much detail as possible. In standard clinical practice, essentially this is often considered to be subjective information that would hopefully then direct the GP towards the next steps in terms of physical examination which aids the process of objectively confirming or refuting any suspected condition(s) or diagnoses.

5.46. In all of the seventy-six[15] reports I reviewed, it is my view that the details provided within sections 4 and/or 5 were adequate and otherwise contained an appropriate level of detail. This is understandable from the medical perspective as I have outlined above.

[15] Whilst it was outside of my terms of reference to consider the care being provided in other Immigration Removal Centres, it is notable that the Rule 35 (3) reports I reviewed from other detention centres fell down in the same areas as for those completed in Brook House.

5.47. The second criteria I looked at concentrated on section 6 of each Rule 35 (3) report. As outlined above, there are a number of important conclusions to be reached by the completing GP. In my opinion, it is at this stage that I found areas of inadequacy in the completion of this section of the Rule 35 (3) reports. I have based this opinion having tried to place myself in the position of the receiving caseworker within the Home Office and tried to visualize what information might be most useful. In approximately three quarters of the Rule 35 (3) reports I reviewed, it is my view that the completion of section 6 was inadequate. I generally found that this was either because no conclusion was reached by the completing GP in regard to the possibility of previous ill-treatment or in the vast majority of these cases because no conclusion was reached in regard to the impact of ongoing detention.

5.48. Therefore, of the seventy-six Rule 35 (3) reports that I reviewed, only a small proportion, approximately a quarter, would in my opinion, be considered adequate overall as they contained both a sufficient level of detail in sections 4 and/or 5 as well as providing a conclusion in regard to the impact of ongoing detention in section 6.

5.49. In respect of the inadequate Rule 35 (3) reports, it is not clear to me whether there is a mechanism by which reports would be reviewed and feedback provided to the writer in order to obtain additional and/or appropriate levels of detail, particularly in regard to section 6. A system by which feedback could be provided to the writer of the report would be a helpful mechanism by which there could be a continual process for quality improvement of the provision of the reports. Where there were repeatedly poor reports, this would be helpful in identifying potential training needs of the writer(s) or prompt exploration for any other reasons that may be contributing to the inadequacy of the content, such as time constraints,

lack of interpreting services or other factors. There does not appear to be any clear system for a dialogue between the GPs and the Home Office for case discussion where additional information or factors could be discussed in a dynamic approach to the completion of the Rule 35 (3) process.

5.50. The inadequate reports I have seen do not raise any concerns from my perspective in terms overall competency of the GP or fitness to practise given that this is only one component of the overall care they are responsible for providing.

5.51. I have not been formally provided with any Rule 35 (1) or Rule (3) reports from other immigration removal establishments for comparison with those I have seen from Brook House nor been asked to consider the wider comparison of practice between establishments. It is noted that within the Shaw follow-up report[16], there is a detailed review of the numbers of detained persons for whom a Rule 35 report was completed and the proportion of those released from detention in view of the Adults at Risk policy.

5.52. As outlined above, having reviewed the seventy-six Rule 35 (3) reports, it is my view that approximately three quarters of these contained an inadequate level of detail within section 6 as no conclusion was reached in regard to the possibility of previous ill-treatment or in the vast majority of these cases because no conclusion was reached in regard to the impact of ongoing detention. In my view, this is understandable from the perspective of the GP and there may be a number of factors to consider.

[16] Stephen Shaw report of July 2018: Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons

5.53. In some cases, the GP may be preferring to avoid providing an opinion as they may feel this is outside of their level of competence on the basis that they do not feel sufficiently specialist in this area. In some cases, the GP may be leaning towards offering a more neutral position on order to avoid appearing biased one way or another in regard to the detained person's case.

5.54. In many of the examples I reviewed, the GP has couched their conclusion in terms of *'may be consistent with…'*, *'may have been tortured…'* which appears to suggest that there was an expectation that there would be further interpretation and/or decision-making by the caseworker. It is particularly noticeable how infrequently the GP made a determination in regard to the negative impact of ongoing detention. Again, from my perspective this is understandable as the GPs are likely to feel less confident in predicting deterioration, especially when they have not met previously or known the detained person for very long. Although I have not looked at the merits of each case where the GP concluded there would be a negative impact with ongoing detention, there are cases where a longitudinal relationship does appear to provide sufficient evidence to reach a firm position.

5.55. Not all forms of torture or ill-treatment will result in visible scarring. However, in the cases where there are visible scars, it is important in terms of drawing conclusions, that the history described by the patient is relatable to the examination findings. This is largely an acquired skill and is more often than not the domain of experienced Emergency Department doctors and/or Forensic Medical Examiners who are routinely asked to consider the consistency of the injuries reported to them with the physical findings on examination, and in some cases provide expert opinions on these matters in Court. It is notable that in section 3 of the Rule 35 (3), it specifically states that *'… This is a factual report rather than a medico-legal one'.*

It is fair to say that the vast majority of GPs would not ordinarily have this level of skill or expertise and would not normally be able to maintain competency in this area unless they were regularly working in an Emergency Department or as a Forensic Medical Examiner as '**normal**' General Practice does not encounter significant levels of acute injuries requiring this level of detail. This may, in part, explain why some of the conclusions reached within section 6 of some of the Rule 35 (3) reports are, in my view, inadequate.

5.56. A further aspect of the Rule 35 (3) process that I found confusing is that the preamble contained within section 3 clearly states: *'I have examined the detainee named above in my capacity as an immigration removal centre medical practitioner and hereby report that I have concerns that the detainee may have been a victim of torture...'*. To my mind, this suggests that simply by completing this report, the GP is essentially providing an affirmative view of this statement. I am not sure whether this is the view held by the GPs completing these reports and or the Home Office caseworkers or not. I am not sure if there are any cases where the GPs have been asked to assess a detained person for a Rule 35 (3) report and on the basis that they do feel they have sufficient evidence from the patient, they opt not to complete a report at all.

5.57. The other question that this process raises is whether, where there is a case in which it was concluded that detention was noted to be having a negative impact on the detained person, a Rule 35 (1) report ought to be completed in addition to the Rule 35 (3) report. Section 3 of the Rule 35 (1) report states: *'I write in respect of the detainee named above in my capacity as an immigration removal centre medical practitioner. I hereby report that this detainee's health is likely to be injuriously affected by continued detention or the conditions of detention'*. It does not appear to be the case in the small number of Rule 35 (3) reports

that I have seen where the GP has concerns about a detained **person's** ongoing detention that a Rule 35 (1) is also subsequently completed. I can see that having to complete two reports would be onerous and an unnecessary duplication of work, especially when it is considered that there also needs to be completion of the IS 91 RA Part C form.

5.58. Example of an adequate Rule 35 (3) report[17]:

Section 4

Says he informed Home Office 01/04/2017 of this torture. He escaped DPA *Iraq and made his way to Turkey for safety where he was forced to work as a slave for a group of Kurdish Mafia, for a period of 3 years during which he was a cook but endured torture. He was made to be a slave for 3 years in Turkey for a Kurdish mafia group. They would beat him with wood to the back of head.* [redacted]. *He tried to kill himself 1 x in Turkey and 2 x in UK. In the IRC, he informs me that he becomes tearful and explains he walks around ashamed thinking that others will know all about him, especially those from his country. He feels he wants to die. He feels no one cares about him and there is no place for him. He has difficulty sleeping. He has a brother in* DPA *and he wishes to live with him. He thinks of his dead mother every day, who was killed in Iraq. He is unsure of the whereabouts of other family members. He has says he always has bad dreams of the events from 2008. He also mentions that 2 months ago he was physically attacked in* Sensitive/Irrelevant *by a group of random men who hit him to the back, but there are no scars present. He says he did attend hospital.*

Section 5

[17] CJS000872 – Rule 35 (3) report - Detainee D2567 - 13/04/2017

He appears vulnerable. He does have some scarring to his foot but no other marks. In addition to the scars he has mentioned has also evidence from self-harming 03/0412017 whilst at IRC. He has been seen by mental health team and has difficulty sleeping and displays symptoms of depression and general low mood. As mentioned

Section 6

He describes a 3 year period of slavery with periods of physical and sexual abuse (and torture). I think there is a strong likelihood of torture and deterioration in this environment (note self harm). He appears a credible individual. His scars are consistent with his account despite paucity.

5.59. Example of an inadequate Rule 35 (3) report[18]:

Section 4

'This patient mentions at the age of 9 he was in Afghanistan in a town called DPA *province he was living in* DPA*. He claims the* Sensitive/Irrelevant *took his whole family as his father was a commander of* Sensitive/Irrelevant *and had defected against them. Pt mentions he was taken and separated from his brother and mother. He mentions his father was shot in front of him. The patient mentions his hand was cut and he was told if he was to make a noise he will be shot. He was told he should be with* Sensitive/Irrelevant *and was forced to join them. He mentions that his father* ***didn't*** *want to work with the* Sensitive/Irrelevant *due to a difference in ideas and this led to his family being captured. This patient mentions he was kept for 3 years between ages 9-12, being trained with guns and then was helped by his uncle to escape. He was brought to the UK shortly afterwards where he claimed asylum. The patient mentions he* ***wasn't*** *believed regarding his account 10 years ago*

[18] CJS002461 – D523 - Rule 35(3) report dated 10.3.17

and his asylum was rejected. The patient mentions not having contact with his mum in the last 10 years. He mentions he ***doesn't*** *have anyone in Afghanistan who can help him. He has currently no family and has lost local knowledge, practices and language. He fears being targeted due to his* ***father's*** *connections and his own defection from Taliban and also due to his inability of adhesion and isolation into that* ***society'***

Section 5

Patient mentions he has a scar on the arm, he showed me a round scar on the left middle of the arm 3 cm over the cubital fossa. The patient mentions this was the cut on the arm that the Taliban had done when they shot his father.

Section 6

The patients scar may be due to his account of what happened. His story is consistent.

Case Studies

I have inserted relevant entries from the records and within these corrections have been made for minor typographical errors, clinical codes have been removed and the material in square brackets has been inserted to make the notes more readily comprehensible.

D1527

D687

D720

D1538

D1914

Case D1527

5.60. In summary, this case relates to a DPA year-old gentleman of Egyptian origin who was transferred from HMP Belmarsh to Brook House Immigration Removal Centre on 04 April 2017.

5.61. On 04 April 2017 the Person Escort Record[19] for the transfer of D1527 from HMP Belmarsh to Brook House Immigration Removal Centre included details that he was on an open ACCT (Assessment, Care in Custody and Teamwork) document and set out his assessed risk to others and offending history.

- The ACCT process is the equivalent process within the prison system for the multi-disciplinary approach to observing and supporting an individual at risk of self-harm and or suicide or who may be vulnerable for some other reason. The approach to the rationale and use of ACCT and ACDT are broadly similar.

5.62. On 04 April 2017 at 19:26 staff nurse Lyn **O'Doherty** recorded in SystmOne[20]:

> *History: Quiet on admission and on ACDT for suicide threats - 3 abs per hour. S/B DCM sand for single occ room*
> *until review No current thoughts of self harm or suicide. RMN referral made and given slip to attend MO appt tmrw.*
> *Observation of appearance of skin - some superficial self harm cuts on arms*
> *Never - denies*
> *Health related observations about the prisoners physical appearance - no current issues*
> *Has no outstanding hospital/ Doctors appointments*

[19] CJS001129 – Person Escort Record Form dated 4/4/17.
[20] CJS001002 – Patient Record of D1527 beginning 16.11.2016

Unknown

Not disabled

Prisoner has tried to harm themselves (outside prison) - say she took overdose of tablets? name and was hospitalised

Prisoner has a psychiatric nurse or care worker in the community : no

Prisoner has tried to harm themselves (in prison)

Fit for normal location, work and any cell occupancy - DCO says he will be single occ tonight

Impressions of the prisoners behaviour and mental state - appears quiet compliant but would not elaborate

Sexual orientation not given - patient refused

Prisoner has been in prison before - Transferred from HMP Belmarsh

Adult male

No known allergies

Medical/psychiatric report not required: no

Fit to attend gym

Born in Egypt

Health information received from outside source

Speaks English well

Main spoken language Arabic

Sensitive/Irrelevant

O/E - height **Sensitive/Irrelevant**

O/E - weight

Pulse rate 82 bpm

Intentional non-attendance at school

Second Reception Screening

Unable to write

Able to tell the time

Unable to read

Prison first reception health assessment completed

Has not stayed in a psychiatric hospital

No suicidal thoughts

Emotional state observations - appears quiet -reluctant to talk much

Has not received medication for mental health problems - says he was taking antidepressant which states did not help
Prisoner has not received treatment from a psychiatrist outside prison: no
Open F2052SH - suicide threats
Referral for mental health assessment
Prisoners alcohol intake week before custody 0 Units/ Week
No thoughts of deliberate self harm
Non-smoker
122 / 81 mmHg
Referral to [D1527]
Client ID Amendment - Prison number changed from [redacted]
Medication In Possession Status: Not in possession

5.63. On 04 April 2017 staff nurse Lyn **O'Doherty** made a referral[21] to the mental health team:

*Transferred from Belmarsh HMP-full notes not seen on admission but currently on ACDT due to suicide threats. States he was on antidepressants but they **haven't** helped. Quiet on admission and has hx of self harm but **didn't** want to elaborate.*

- The referral by nurse **O'Doherty** indicates clear concerns for **D1527's** current mental state and in keeping with his transfer into the establishment, it is my view that it was reasonable to request an assessment by the mental health team.

5.64. On 04 April 2017 the ACDT Record of Case Review[22][23] was commenced. This was closed on 27 May 2017.

- This is a period of nearly eight weeks.

[21] CJS000961 – Mental Health Referral Form for detainee dated 4/4/2017
[22] CJS001049 – Assessment review re D1527 dated 4.4.17 - 21.4.17
[23] CJS001035 – Record of case reviews re D1527

5.65. On 05 April 2017 at 15:20 Dr Saeed Chaudhary recorded on SystmOne:

History: pt mentions has been on antidepressants in the past, mentions has had mental health issues in the past,
looking at notes was previously on citalopram Issued the same adn advised to see Mental health team, not actively
suicidal. review by RMN.

- Dr Chaudhary prescribed citalopram 20 mg – one tablet daily (28 tablets) (Future dated medication 08 April 2017)

- Citalopram is a selective serotonin re-uptake inhibitor (SSRI) and is considered a first-line option for the treatment of depression (and anxiety).
- It is my assumption that Dr Chaudhary made the prescription on 04 April 2017 but made provision for the medication to commence on 08 April 2017 in order to allow sufficient time for the prescription to be delivered to the relevant pharmacy service; for the medication to be dispensed and returned to Brook House and for the medication to be administered to D1527.
- It appears that this is a not-in-possession medication which would be considered appropriate given that D1527 was on an open ACDT at the time this prescription was made and it would have been relevant to consider the risk of overdose in these circumstances.

5.66. On 07 April 2017 at 16:48 mental health nurse Karen Churcher recorded on SystmOne:

History: ACDT review
Examination: Seen on wing with DCM H Attwater.
Would not maintain eye contact Not happy that he has had to wait a couple of days for his medication to arrive.
Is frustrated regarding his immigration status.

Not sleeping well but makes sure he does not sleep during the day. Finds night time hard as during the day he can occupy himself.
Plan: Observation levels to continue

5.67. On 11 April 2017 a 10:59 nurse Donna Batchelor recorded on SystmOne:

History: complaining of coughing for 5/7 days feeling wheezy when lying down struggling to sleep
requesting rule 35
Examination: there was incident on bus back in egypt where he was neatly [sic] *killed, he claims a knife was used he*
states several scars. claims also beaten with stick
states was by family members.
[redacted] *and that he will be persicuted* [sic] *if he returns back*
Plan: requeting [sic] *to see M/O*
Pre rule 35 appointment given

5.68. On 12 April 2017 at 12:00 mental health nurse Karen Churcher recorded on SystmOne:

History: ACDT review
Examination: Seen on wing with DCM H Attwater.
Feeling physically better since commencing antibiotics.
Has had a pre assessment for rule 35 and has a mental health appointment this afternoon.
is eating and drinking and has not self harmed since last review
Plan: Observation levels reduced to 4hourly with one conversation daily.
Next review set for 15/4/17

5.69. On 12 April 2017 at 15:35 Dr Husein Oozeerally recorded on SystmOne:

History: 5 days cough non productive
R35 Arabic.
In Egypt, [redacted]. *He was kept for two days without food and he was tortured for 2 days.* [redacted]. *He says that it was* [redacted] *that tortured him. This was not reported to police.*

Scars on the right forearm, right index finger, on the chin .
small scar above the right eye brow.
small circular on the right medial ankle
Examination: T37.0 98% in air p85
chest clera.
red orophaynx
Plan: R35 tomorrow
URTI. conservative Mx [management] *only*
O/E - pulse rhythm regular
Pulse rate 84 bpm
125 / 75 mmHg

- It is not clear from this entry whether there were time or other constraints preventing Dr Oozeerally from undertaking a Rule 35 assessment at this time or whether **D1527's** priority was in regard to his physical health on this occasion.

5.70. On 12 April 2017 at 18:02 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Seen for assessment.
Presented as low in mood and tearful at times. Blunted affect with poor eye contact and quietly spoken. Signs of anxiety but not agitation present.
No visible signs of psychosis or thought disorder.
History:
[redacted] *They tortured him. Put a knife to his neck and stated that they wanted to kill him slowly.*
Did not elaborate on how he escaped, but made his way to Italy. He was aged 14 at the time.
When asked if he was in contact or had family back home, declined to comment.
Arrived in Uk 3 years ago and has been in prison but the charges were dropped. Is worried that they will send him back to prison.
Has friends in UK but no family.

Presenting mental health issues-
Presents as depressed and is on medication but has not taken for last 2 days. Advised to set alarm on his phone to remind him to collect from health care.
Superficially self harmed at the weekend. Given elastic bands and advised on how to use them.
States he has active thoughts to kill himself. Has a plan to hang via his bed sheets. Kicking over the chair so that he dies.
Informed that Oscar 1 would have to be informed about his disclosure. Was not happy as he does not wish to be watched, just wants to die.
Worked on positive forward thinking.
Sleep-
Sleeps for about 4hours a night and does look visibly tired. States he has nightmares which wake him.
Appetite-
He eats, does not appear to have lost weight.
Activities-
Tries to keep himself busy by playing pool and is busy with his case.
Immigration issues-
Has a solicitor but is not sure what they are doing.
Advised to contact to find out.
Plan: Oscar 1 informed regarding his disclosure of suicidal ideation.
Rule 35 appointment booked for 13/4/17
Mental health follow up se4ssion [sic] *booked for 13/4/17 at 18.30*

5.71. On 13 April 2017 at 09:42 Dr Husein Oozeerally recorded on SystmOne:

Problem [V] Victim of torture
History: Arabic.
P0027797 [Interpreter number]
I clarified the account from yesterday.
Manner of torture:
He says that he was tied up and attacked with a knife on the first day. He was then deprived of food for the remainder of the time and beaten with fists to his face and body. They would sometimes use wood and sticks.

He has difficulty sleeping. He occasional has memories of what has happened in the past but his feeling relate to his experiences, as well as the immigration case. He says there are two issues. He says he was seeing mental health team regularly before detainment and is currently on antidepressants.
He says he tried to kill himself in Belmarsh prison and he does not regret doing this. He has met with mental health
team at the IRC and given a plan of how he plans to kill himself. He says he has negative thoughts every day and
tried to end life 3 days ago. He is now currently on ACDT
Plan: R35 done
[V] Victim of torture
Clinical Letter to [D1527]
[V] Victim of torture

5.72. On 13 April 2017 Dr Husein Oozeerally completed the Rule 35 (3) Annex C report[24]:

Section 4
R35: Arabic. Big Word used
In Egypt, [redacted]. *He was kept for two days without food and he was tortured for 2 days.* [redacted] *This was not reported to police. He says that he was tied up and attacked with a knife on the first day. He was then deprived of food for the remainder of the time and beaten with fists to his face and body. They would sometimes use wood and sticks.*

Section 5
Scars on the right forearm, right index finger, on the chin
small scar above the right eye brow
small circular on the right medial ankle
He has difficulty sleeping. He occasional has memories of what has happened in the past but his feeling relate to his experiences, as well as the immigration case. He says there are two issues. He says he was seeing mental health team regularly before detainment and is currently on antidepressants.

[24] CJS001123 – Home Office Rule 35(3) Report dated 13.4.2017

He says he tried to kill himself in Belmarsh prison and he does not regret doing this. He has met with mental health team at the IRC and given a plan of how he plans to kill himself. He says he has negative thoughts every day and tried to end life 3 days ago. He is now currently on ACDT.

Section 6

He appears credible. He may be a victim of torture and his scars are consistent with the account. He clearly has mental health issues but I am unsure whether detainment has a negative impact on this as he has tried to harm himself in the community.

- The conclusion reached by Dr Oozeerally on this occasion does raise a number of points:
- Firstly, there is no requirement within the Rule 35 (3) report or Adults at Risk policy requesting the writer to provide their view on the '**credibility**' of the detained person. This is essentially unnecessary given that as the report has been completed by a medical professional on this occasion and otherwise reaches the threshold for '**professional evidence**'.
- Secondly, Dr Oozeerally has made a comment that he is '**unsure**' of the impact that detention is having on D1527 at this time. This is understandable given that D1527 had only been received into Brook House nine days earlier.
- Thirdly, and importantly, Dr Oozeerally appears to raise an issue by including in his statement '... *as he has tried to harm himself in the community*'. In my opinion, Dr Oozeerally included this in his statement with the intended meaning that as **D1527's** risk of self-harm was present in the community, it was not clear whether his period in detention had altered/increased his risk of self-harm. This is a preliminary view based on the material provided to date and until such time that I receive further evidence that assists in providing further explanation for the wording in this report.

5.73. On 13 April 2017, the letter[25] from Duncan Lewis Solicitors Limited was sent to the Home Office:

> *Dear Sirs*
> *NAME OF CLIENT:* [D1527]
> *DOB:* **DPA** *(disputed)*
> *NATIONALITY: Egyptian*
> *HO REF:* [redacted]
> *We write on behalf of the above-named client, for whom we are already on record. Today, 13th April 2017, our client underwent a Rule 35 Assessment at IRC Brook House conducted by Dr Oozeerally (enclosed), in which he states:*
>
> > *He appears credible. He may be a victim of torture and his scars are consistent with the account. He clearly has mental health issues. but I am unsure whether detainment has a negative impact on this as he has tried to harm himself in the community.*
>
> *Whilst we are pleased that Dr Oozeerally has recognised our client may be a victim of torture and has clear mental health issues, it is extremely concerning that he has not come to a conclusion on whether detention has had a negative impact on his mental health. Our client has active plans to take his life, which have been acknowledged by you and led to the operational decision to place him on constant watch. It is therefore essential that the Secretary of State for the Home Department is in possession of all the necessary information before she reviews the Rule 35 Report under the Adults at Risk policy.*
>
> *The Secretary of State for the Home Department's Adults at Risk in immigration detention states:*

[25] HOM000215 – Letter from Duncan Lewis to Immigration Enforcement re Rule 35 Report and Adults at Risk policy, 13 April 2017

> *On receipt of a Rule 35 report, the decision maker should review the report to ensure that it meets the required standards and, if the report does not meet the required standards, it should be returned to the medical practitioner with a request for the necessary information.*

It is clear that this Rule 35 Report does not meet the required standards for assessment under the Adults at Risk policy. The impact of detention to date and the likely impact of on-going detention on the health of our client will central [sic] *to the Secretary of State for the Home Department's decision on which category of evidence this Rule 35 Report should be considered within. The Rule 35 Report must contain a clear statement on the impact of detention on our client's mental health.*

On 6th April 2017, we submitted a letter from Tiago Brandao (enclosed again for your convenience), a mental health professional who previously worked with our client. His letter stated serious concerns about the continued detention of our client:

> *I strongly believe that, for his recovery,* [D1527] *needs intense and specialist support which can ensure that he is appropriately medicated and complying with his treatment as well as receiving the emotional support and therapeutic input he so desperately needs. Keeping this in mind I believe that is extremely dangerous for his young person to be detained in a place that does not provide this support.*

We request that you immediately remit this Rule 35 Report back to Dr Oozeerally at IRC Brook House for urgent reconsideration of these issues. The doctor should be referred to the letter of Tiago Brando and the copious evidence available in our client's medical records, which strongly suggests that his mental health conditions have precipitous deteriorated since his detention began.

In addition, we submit that when reviewing our client's Rule 35 Report, you must also consider the letter from Tiago Brando, which provides a clear assessment that continued detention will be harmful to our client. When read together, the Rule 35 Report and Letter from Tiago Brandao amount to Level 3 Evidence.

[...]

- The letter from Duncan Lewis Solicitors does offer a view on the content of Dr **Oozeerally's** Rule 35 (3) report. It is not clear whether the concerns raised in this letter were fed back in any way by the Home Office to Dr Oozeerally.
- I could not locate a copy of this letter attached to **D1527's** SystmOne record.

5.74. On 17 April 2017 at 22:44 nurse Mariola Makucka recorded on SystmOne:

History SOB [shortness of breath]*, Depressed mood*
Examination: Seen in his room at approx 22.00 as detainee complaining if SOB.
Vital signs check sat 99%,130 / 79 mmHg, pulse 78,resp 16 ,temp 364
Detainee complaining of poor sleep and states that is forgetting things.
Do not remember to come for his medication and too attend RMN app?
While had conversation with him express that self-harm today afternoon -cut his left upper arm .
3 superficial cut mark observed -do not required dressing.
When ask about any self harm or suicidal thought express that do not know. Oscar 1 inform.
Detainee is on ACDT and 2 hrl abs.
Has RMN app tomorrow afternoon and advice him to come
Found on his table box of Amoxicillin 500mg dated 07/04/17 1 capsules only was taken
When asked why was not taken this ATX [sic] *states taht* [sic] *was better and do not want to continue?*

5.75. On 18 April 2017 at 11:55 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History: ACDT Review
Attends [D1527] *review with H. Attwater in B wing office. Appears very low in mood, mumbled at times when answering questions. Said he spoke with his solicitor and he said nothing is going on at the moment. so he just has to wait. Asked, what would we say if he tells us that he sent to prison wrongfully and taken here after? Says he*

doesn't know if he is feeling low after he was questioned about his feelings.
It was reported that [D1527] *wasn't taken his prescribed medication for the past 3 days, because he states that he can't remember to go for his medication. Was advised to used the alarm on his mobile phone to remind himself of when he needs to go to healthcare for his medication, staff will also remind him whenever his medication is due.*
Said he will do this.
Encouraged to continue socialising, as he was seen doing so with other detainees before his review by wing
officers and to seek help whenever he has any concern.
There was no active/current suicidal thoughts or self harm ideation reported.
Has appointment for his medication to be reviewed this afternoon.
Plan: Hourly Observation.
ACDT review on the 19/04/17

- In my experience, there may be a number of reasons for people not attending for the not-in-possession medication. The suggestion from this entry is that D1527 was struggling to remember to attend the medication hatch, which may be a result of his current mental state but may be a result of other factors that are not known.
- There is an important principle to consider in regard to the provision of treatment within secure settings which is that there ought to be an appropriate level of responsibility given to the patient to be concordant with their treatment as this cannot otherwise be enforced upon them. I would not expect nursing staff to routinely transport medication onto the wing to deliver to a detained **person's** room. Ultimately, there needs to be a careful balance between encouragement of personal responsibility for treatment versus being coercive or applying contingency management.

5.76. On 18 April 2017 at 15:23 Dr Saeed Chaudhary recorded on SystmOne:

History: Patient mentions has been depressed and low in mood but not really taking medications. Advised patient to take meds, moved to evening and laso [sic] *added sleeping tabs to help. review if not improving.*

- Dr Chaudhary prescribed citalopram 20 mg – one tablet daily (14 tablets) and promethazine hydrochloride 25 mg – 1-2 tablets (10 tablets)

5.77. On 18 April 2017, the Home Office provided an IS.335 response[26] to the Rule 35 (3):

I am writing to you to acknowledge receipt of a report dated 13 April 2017 provided by the medical practitioner at Brook House IRC Removal Centre notifying us of a special illness or condition. Information contained within the report has been considered carefully and the decision to detain you has been reviewed.

Careful note has been taken of your account which has been outlined in the Rule 35 report. You claim that whilst living in Egypt [redacted]. *You were kept for two days without food and tortured.* [redacted]. *On the first day you were subjected to torture with a knife. You were deprived of food and beaten with fists about the face and body. Sometimes they would use wooden sticks.*

On 13 April 2017 the medical practitioner conducted a mental and physical examination of you. They documented that you had scars on your right forearm, right index finger and on your chin. There was further scaring above your right eye brow and a small circular scar on your right ankle. The medical practitioner noted that you informed he you have difficulty sleeping. On occasion you have memories of what happened in the past but also include your feelings in regards to your immigration case. You have been seeing a mental health team prior to your detention and taking antidepressants. You claim that you tried to kill yourself at HMP Belmarsh and you do not regret doing this. You have met with the mental health team at the detention centre and told them you were planning to kill yourself. You have negative thoughts every day. You are on an open ACDT.

The medical practitioner concluded that it appears your account is credible and that you may be a victim of torture. The scars are consistent with your account. You clearly have mental health problems however he was unsure whether detention was having a deleterious impact upon you as you had tried to harm yourself whilst you were in the community.

[26] HOM000644 – Letter from OP Nexus High Harm Team (Home Office) to D1527 re Rule 35 report

Your claim of ill-treatment has been considered in line with the guidance set out in the 'Detention Services Order 9/2016' as well as the 'Adult at Risk' policy, Although under the current policy the definition of torture is that which is outlined by Article 1 of the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), for the purposes of this Rule 35 report, the following definition given in the case of EO & Ors. [2013] EWHC 1236 (Admin), has been applied:

> *"**Any** act by which severe pain or suffering, whether physical or mental , is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or coercing him or a third person, or for any reason based on discrimination of any **kind.**"*

In relation to your claim of ill-treatment, your account of ill-treatment does meet the above definition of torture. Accordingly, you are regarded an adult at risk under the policy. Your detention has been reviewed and the report carefully considered when determining your suitability for detention under the 'Adult at Risk' policy.

Immigration factors

You claim to have entered the United Kingdom on or around 16 January 2014 by clandestine means being concealed in a lorry. You attended Croydon Asylum Screening Unit on 23 January 2011 and claimed asylum. Your asylum claim was based upon your perceived fear that due to your father's association with [redacted]*, you would face persecution from the army if returned to Egypt. You claimed to be 15 years old however this was disputed. You were referred to Social Services.*

On 11 February 2014 you attended an asylum screening interview. You were served with illegal entrant paperwork (1S151A).

On 21 March 2014 you were assessed as a minor by Social Services and were given the date of birth of **DPA** *, making you 17 years old.*

Your asylum substantive interview was completed on 10 April 2014. Your asylum was refused on 28 November 2014. You lodged an appeal on 28 December 2014. This appeal was dismissed on 8 October 2015 and your appeal rights were exhausted on 27 October 2015.

On 5 October 2015 you were arrested by police under suspicion of [redacted]

On 7 October 2015 you failed to report to immigration as per your reporting conditions. You were listed as an absconder on 28 January 2016.
On [redacted] *you were convicted of* [redacted].
On [redacted], *you were convicted of* [redacted].
You were arrested by police on 14 November 2016 under suspicion [redacted]. *It was at this point you came to the attention of the Immigration authorities again. You were remanded into custody.*
On [redacted] *you were found not guilty of* [redacted]. *A decision was made to detain you due to your criminality and failure to comply with release conditions. You were served with a notice of a person liable for removal (RED0001) as an illegal entrant.*
An attempt was made to interview you in connection with obtaining an emergency travel document on 22 March 2017 however you refused to comply without receiving instruction from your representatives.

Public protection factors
On [redacted] *you were convicted* [redacted]. *You were sentenced to* [redacted]. *This offence was committed whilst you were on bail.*
On 14 November 2016 you were arrested by police under suspicion of [redacted]. *This charge was later dropped. You were also arrested for* [redacted]. *You are due to appear at* [redacted].

Balancing risk factors against immigration control factors
Careful consideration has been given to balance your wellbeing whilst in detention against the risk of harm to the public and the need to maintain effective immigration control.
It is noted that you claim to have entered the United Kingdom sometime around 16 April 2014 by clandestine means. You claimed asylum on 23 April 2014 and stated that you were 15 years old. On 11 February 2014 you were served with the notice of a person liable for removal (IS151A) as an illegal entrant. You were aged assessed as being a minor on 21 March 2014 with a date of birth of **DPA** *making you 17 years old at the time of your claim. You were granted temporary admission.*
Your asylum claim was refused and your subsequent appeal dismissed on 8 October 2015. Prior to your appeal being dismissed you stopped reporting to Immigration. You

were listed as an absconder on 28 January 2016 and you did not come to light again until 14 November 2016.

You have made no attempt to regularise your stay in the United Kingdom following your dismissed appeal on 8 October 2015. Indeed, it appears that your failure to report to immigration after your appeal was dismissed was motivated by your desire to evade removal. You only came to light again following your arrest [redacted]

You have been convicted of [redacted]. *You were sentenced to* [redacted]. *You have subsequently been arrested again for* [redacted]. *You are due to face trial on* [redacted]. *Your conduct shows a blatant disregard for the laws of the United Kingdom. Furthermore, your offending demonstrate that you pose a significant risk of harm to the public - namely females.*

With regard to your Rule 35 report, the medical practitioner accepted that your injuries were consistent with your account you have given and that you may be a victim of torture. The medical practitioner has not made an assessment on whether your continued detention will have a negative impact upon your health although they do state that you attempted self harm whilst in the community.

You have provided the Secretary of State a letter dated 6 April 2017 from Tiago Brandao, a counsellor/psychotherapist who works for Compass Project. The letter states that you have accessed them on three separate occasions having been initially referred on 28 July 2014 by your key worker because of their concerns about your inability to manage your emotions. You were offered counselling sessions but struggled to make use of them due to your dissociating with past feeling and issues. You missed two appointments and your case was closed.

You were referred to Compass again on 27 July 2015 but again you struggled with the sessions. You were referred again to Compass following a suicide attempt where you ended up in hospital on 6 November 2015. You were offered weekly counselling sessions since 3 December 2015 however you found it difficult to attend regularly. You had a total of 12 sessions before you were moved to another borough. During your sessions it became apparent that you have difficulties trusting others, difficulties in concentrating, dissociation signs, possible flashbacks and intrusive memories. In his opinion, Mr Brandao believes that to aid your recovery you need intense and specialist support which can ensure that you are appropriately medicated and compliant with

your treatment as well as receiving emotional and therapeutic input and considers it dangerous to keep you detained in a place which does not provide this support.
Having given regard to this letter along with the medical practitioner report it is determined that your needs are and can be managed sufficiently and effectively by the Healthcare Team within the Immigration Removal Centre.
You are currently being monitored by Healthcare due to your open ACDT having made a statement of intent to self harm. You are currently taking antidepressant which are available in the Immigration Removal Centre. Your detention is being maintained in order to affect your removal from the United Kingdom. With that in mind you have an Emergency Travel Document interview scheduled for 30 May 2017 which is within the next 4-5 week and your detention is justified in order to ensure your compliance with that interview having demonstrated previously that you are unwilling to comply with reporting conditions.
Conclusion
Therefore when balancing the indicator of vulnerability against the negative immigration factors highlighted above and the imminence of your removal, it is considered that the negative factors outweigh the risks in your particular circumstances. Therefore a decision has been made to maintain your detention.
A copy of this letter has been forwarded to your legal representative, where you have one.

- The letter is very clear in regard to the information being weighed and does present a decisive view on the reasons for continued detention. However, I should make it clear that except for clinical issues, the assessment made by the Home Officer and the factors being considered are outside of my area of expertise.
- This letter from the Op Nexus High Harm Team is attached to **D1527's** SystmOne record. It is not clear whether this information is reviewed by a member of the healthcare team, or specifically the GP completing the Rule 35 (3) report.
- It is not clear whether the receipt of a letter of this nature was subject to any multi-disciplinary review and/or action by the healthcare team.

5.78. On 19 April 2017 at 08:39 nurse James Newlands recorded on SystmOne:

History Refusing food
Examination: Seen this morning on day 1 of food refusal.
Did not want to engage in conversation with me or allow me to complete physical health checks.
BRAG rating: Green
Plan: Continue to monitor as required

- This appears to be the first day on which D1527 had indicated that he was refusing food. It is not clear from the records whether this was in direct response to receiving the IS.335 letter from the Home Office in which the conclusion reached was that detention would be continued and that deportation was relatively imminent.
- From a clinical perspective, it is understandable that this kind of decision would have a negative impact on the detained **person's** feeling of hope with regard to the prospect of release from detention and fear of being returned to their country of origin.

5.79. On 21 April 2017 at 17:51 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Arrived for his appointment 20 minutes late, despite being called.
Would not maintain eye contact.
His visitor did not come yesterday and he stated he did not know why. When asked if he had spoken to them he changed the subject.
Stated his social worker has not picked up his clothes for him, not sure if this was the visitor he was expecting.
Home office have not released him despite receiving his rule 35. It was explained that often if there is a risk that he may harm himself they will not release as detention is a safer place for him.

He than [sic] *stated he just wants to die. Does not matter if in here, outside or in another country.*
When asked why he wanted to die he could not answer.
Was encouraged to future plan and think of all the things he wanted to achieve, but remained very negative.
Oscar 1 informed.
Plan: Follow up session booked for 22/4/17 at 18.30

- This entry by nurse Churcher further suggests that there were concerns for **D1527's** welfare should he have been released from detention and there was an offer of reassurance in trying to explain that detention was *'**a safer place**'*.

5.80. On 22 April 2017 at 10:10 mental health nurse Karen Churcher recorded on SystmOne:

History Refusing food Day 1
Examination: Seen on wing.
States he is drinking water but does not feel like eating.
Declined to have his physical observations completed.
Plan: BRAG rating Green

5.81. On 22 April 2017 at 10:58 mental health nurse Karen Churcher recorded on SystmOne:

History: ACDT review
Examination: Seen on wing with DCM H Attwater.
Continues to non communicative with only monosyllabic answers.
Hard to gauge mood as presenting as low, with poor eye contact at his reviews. But observed at other times in communal areas playing pool and laughing with fellow detainees.
Continues to state that there is no point in anything.
Plan: Continue on hourly observations with mealtime observations on top.
Review 23/4/17

5.82. On 22 April 2017 at 18:44 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Did not attend his mental health appointment despite seeing me at the time of the appointment by the
shop.
He smiled and joined the queue for the shop.
He was observed laughing and joking with fellow detainees
Plan: follow up appointment booked for 27/4/17 at 11.30

5.83. On 23 April 2017 at 09:16 nurse James Newlands recorded on SystmOne:

History Refusing food
Examination: Seen this morning on the wing to complete physical health checks on day 2 of refusing food. He declined to have any observations done or engage in conversation.
BRAG rating: Amber
Plan: Continue to monitor as required

5.84. On 23 April 2017 at 22:24 staff nurse Janina Wingert recorded on SystmOne:

History: 22:20 Officer asked us to see this detainee as he will not communicate with them. When arrived detainee said he has headaches but declined to have any painkillers, that he can not sleep and the Promethazine that was prescribed for him does not help him much and would like something stronger. Advised him to atten to his RMN appointments. Also mentioned that sometimes he hears voices that tell him what to do. Did not want to give me any further informations.
Examination O/E - blood pressure reading 128/75 mm Hg, O/E - pulse rate 78 bpm,
Plan: Dr appointment booked.

5.85. On 24 April 2017 at 00:21 staff nurse Janina Wingert recorded on SystmOne:

History: Attended first response as room colleague was concerned as [D1527] *has cut himself. When arrived detainee has declined to show us his arms and did not want to speak with anybody. Was keep on saying live me alone, I don't want to speak with anybody. Asked him he still has headache and if he wants any painkillers and he*

declined, informed him that I booked a Dr appointment for tomorrow and he replyed [sic] *he does not want to see any Dr. Oscar 1 explained to him that if he does not let us see him he will have to be moved in an Observation room. Eventually, detainee agreed to show us his arms and we notice 2 superficial cuts on his left wrist. When asked why he did this said he does not know. Declined any other medical interventions. Oscar 1 took the decision* [sic] *to move the detainee to E Wing*

5.86. On 24 April 2017 at 09:11 nurse James Newlands recorded on SystmOne:

History Refusing food
Examination: Seen this morning on Ewing to complete physical health checks on day 3 of refusing to eat. He did not want to engage in conversation with me or allow me to complete physical health checks.
BRAG rating: Amber
Plan: Continue to monitor as required.

5.87. On 24 April 2017 at 13:40 Dr Husein Oozeerally recorded on SystmOne:

History: See in Ewing.
When I entered the room, he was asked if an medical issues, he has said there are none.

5.88. On 24 April 2017 at 22:15 nurse Mariola Makucka recorded on SystmOne:

History: ACDT & constant supervision
Examination: Seen on Ewing room 1 as detainee is place on constant supervision.
Offered his night medication but detainee refused sttaes [sic] *will not take any medication until will not return to normal wing*

5.89. On 24 April 2017 IS.91RA Part C: Supplementary Information to IS.91 RA Part A[27]

Detainee [D1527] *has now been placed onto a Constant Supervision after attempting to ligature with his bed sheets.*

[27] CJS001073 – IS.91RA Part C: Supplementary Information to IS.91 RA Part A dated 24.04.2017

5.90. On 25 April 2017 at 10:15 Dr Husein Oozeerally recorded on SystmOne:

> *History: Seen in E wing.*
> *Room 1*
> *declined to be spoken to whilst on e Wing*

5.91. On 25 April 2017 at 11:55 nurse Dahlia McNaught-Dowd recorded on SystmOne:

> *History Refusing food Day 4*
> *Was laying in bed covered with his duvet. Refused physical observation. Claims he had not eaten or drank for several days. However, officer on constant supervision confirms that* [D1527] *drank and ate yesterday. Was advised to drink fluid.*
> *BRAG Rating = Amber*

5.92. On 25 April 2017, there is video footage[28] showing the incident as recorded by Mr Callum Tulley:

- The video footage viewed broadly contains three sections:
- Section 1 [00:00 – 06:20]: There is very little that can be deduced from this piece of footage given that there is no clear view of the detained person and no clear description of what was taking place.
- Section 2 [07:09 – 08:09]: This section is approximately one minute in length. CT is heard instructing the detained person to stop doing what he is doing but it is unclear precisely what that was as the video footage does not reveal what the detained person was doing. Within the period of one minute, the detained person appears to have been moved from where he was lying on the floor to another position on the floor and is now being controlled by at least two officers: one controlling his head and presumably CT. It is not apparent whether there were other officers and/or a nurse

[28] BBC00071 – KENCOV1007 – V2017042500021 – 25 April 2017 [00:00-27:49], TRN0000002

also involved or what they were doing although other voices can be heard. By the end of this clip, the detained person appears to be momentarily calm.

- At this stage, depending on what is happening, I would have expected a reasonably competent nurse who was present during this episode to be observing the process of restraint/use of force for any signs of injury arising from any form of excessive control or restraint. This would include, but not be limited to, observing for any hold or application of pressure resulting in excessive pain or injury, i.e. that which went beyond what was necessary in order to obtain compliance from the detained person in submitting to the instructions being provided by the custodial officers. I would have expected a reasonably competent nurse to have been observing for anything that might indicate or suggest any form or signs of life-threatening injury, including but not limited to signs or symptoms of chest pain or airway compromise and be prepared to intervene and treat accordingly. I would have expected a reasonably competent nurse (i.e. one who has had the relevant Use of Force/Control and Restraint training and subsequent refresher training) to be able to identify any locks or holds which were not permitted or if unofficial techniques were being deployed by other staff members and to intervene at the earliest opportunity by instructing the staff to cease or modify their manoeuvre. In the event that the nurse had not completed any Use of Force or Control and Restraint training, I would have expected a reasonably competent nurse to have been able to recognise techniques that may be inflicting harm on the individual and to at least verbally challenge the staff member using excessive force to consider their actions and advise them reduce the intensity in order to avoid injury.
- Section 3 [08:21 – 09:21]: This section is approximately one minute in length. The video footage does not reveal the reasons for the subsequent escalation either in terms of the detained **person's** increased level of agitation or the subsequent response

by the custodial officer(s). There appears to be a period between 08:23 – 08:41 where the officer controlling the detained person's head has effectively throttled the detained person with both hands around the neck at or around the level of the cricoid, apparently resulting in compression of the airway with both thumbs and consequently stopping the detained person from breathing for around 18 seconds. This action appears to be visible to CT who apparently indicates to the officer his concern for the welfare of the detained person. It is not clear from the footage whether there was a nurse present, but in the event that there was a nurse present and they could see what was happening at this stage, I would have expected them to have intervened immediately and that failing to do so would fall below the expected standard.

- Section 4 [09:35 – 15:50]: This section is approximately 6 minutes in length. The detained person appears to have been in a highly distressed state for the whole of this section of the video. It is not entirely clear what the reasons were for the ongoing agitation or why the officers continued to be holding and/or restraining him. It is not entirely clear how the decision was reached to remove the restraint from the detained person. In terms of the nurse who was visible within the room, it is not apparent that she was contributing meaningfully to the welfare of the detained person during the episode of restraint by undertaking any monitoring or relaying any observations to other healthcare staff. I would have expected a reasonably competent nurse to have been monitoring the heart rate and respiratory rate as a minimum and to have been making a record of the observations she had obtained. Given the level of distress of the detained person, it may have been too difficult to obtain peripheral oxygen saturation and blood pressure readings, but these should have been obtained as soon as practicably possible following the de-escalation of the incident. In the event that the

nurse did not monitor the detained person as outlined then this would fall below the expected standard.

- Section 5 [16:09 – 27:29]: This footage shows a detained person in a highly distressed state who is apparently being restrained for an unknown reason. Insofar as it is within my ability to comment, it is my view that the apparent strangulation in the third section of the video is totally unjustified and inappropriate. Whilst it is outside of my area of expertise, from a non-forensic perspective, I would question whether this meets the threshold for a criminal act e.g. physical assault.
- The subsequent level of agitation of the detained person may well have been as a result of the applied stranglehold.
- Section 11 of the Use of Force policy (March 2016) [CJS000360] sets out a list of '**signs**' indicative of a '**medical emergency**' arising from control and restraint.
- I would have expected reasonably competent member of staff to have relaxed or withdrawn their control and restraint holds at the earliest opportunity in line with the policy. In this event, given that there does not appear to have been any particular efforts by the detained person to act violently or to be actively resisting the intervention, it is unclear as to why the control and restraint went on for the extended timeframe.
- I would expect a reasonably competent member of the healthcare team to have been able to recognise unauthorised holds or techniques (based on their control and restraint training) and to have intervened if the members of staff were observed to be utilising any such techniques. In the event that inappropriate or unauthorised techniques were being utilised, I would have expected the initial intervention from a member of the healthcare team to have provided a verbal command to the member of staff to adjust, withdraw or stop the observed manoeuvre in order to make clear to that member of staff and any other witnesses to the event that the guidance was not being

adhered to appropriately. Where a member of the healthcare team failed to intervene in the event of witnessing a member of staff deploying an unauthorised hold and/or that was overly excessive and/or that was resulting in injury, this would in my opinion fall below the expected standard. In the event that the nurse had not completed any Use of Force or Control and Restraint training, I would have expected a reasonably competent nurse to have been able to recognise techniques that may be inflicting harm on the individual and to at least verbally challenge the staff member using excessive force to consider their actions and advise them reduce the intensity in order to avoid injury.

- I would have expected a reasonably competent member of the healthcare team to document their involvement in any incident involving control and restraint of a detained person. This would include completion of an F213 and attachment to the Use of Force Report (form DCF2). I would expect a reasonably competent member of the healthcare team to make a consultation entry in the SystmOne '**journa**l' and to ensure attachment of the F213 report to the clinical record.

5.93. On 25 April 2017 at 18:51 staff nurse Joanne Buss recorded on SystmOne:

Examination: placed on rule 40 constant supervision as he refused to return to Ewing called to Ewing at approx 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 attemted [sic] *to self strangulate.*
angry and not engaging with staff.
hands removed from his neck by staff.

salivating ++
unable to take any observations
visual abs 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: Is review later this evening

- There was no documentation by nurse Buss on an F213 in regard to her involvement in the Use of Force by detention centre staff to remove the ligature from D1527.
- Nurse Buss made no comment in her entry in regard to the apparent use of unauthorised techniques and/or excessive use of force.

5.94. On 25 April 2017 at 23:00 nurse Mariola Makucka recorded on SystmOne:

Overview Notes
Seen on Ewing room 7 as detainee asking for sleeping tablets. Explained that his Promethazine finish 23/04/17. Is place on DR list as he wish to get sleeping tablets.
2x Paracetamol given at 23.00 for neck pain.
Detainee was on the phone, complied with medication, provide good eye contact.
Observed redness mark on both side neck but skin intact
Detainee on constant supervision

5.95. On 25 April 2017 at 19:00 nurse Makucka completed an F213:

Seen on E Wing room [illegible] *by RGN Jo. Detainee had placed a ligature around his neck, removed by staff. After that he went to the toilet and attempt to self-strangulate. Hands removed from his neck. Slightly redness noted on his neck.*

- It is not clear whether nurse Makucka was present for the entirety of the incident with D1527 on this occasion and whether or not they were providing their own account of their involvement or doing so on behalf of nurse Buss.
- Nurse Makucka makes no comment in the F213 in regard to the apparent use of unauthorised techniques and/or excessive use of force.

5.96. On 26 April 2017 at 10:36 Dr Husein Oozeerally recorded on SystmOne:

History: Seen in E wing.
He says he feels well today and no medical problems.
I believe he resented with challenging behaviour overnight but settled and later became cooperative

5.97. On 26 April 2017 at 12:24 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History Refusing food (Ongoing Episode)DAY 5
Was laying in bed, refused physical intervention. Currently on Constant Supervision, refused to engage when seen
re food refusal.
Brag Rating = Amber.

5.98. On 26 April 2017 at 19:16 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History ACDT REVIEW
Attended by D. Rolley, B. Gabriel, D. Haughton and myself. Said he will kill himself because he rather to die here than to be sent back to Egypt. Says he is not looking for release because they are not going to release him. Was asked what can we do to support him, replied by saying he doesn't want anything because there is something coming up, States that nothing is good for him
He said he does not know if he will hurt himself while he was questioned about his thoughts. To remain on Constant
supervision.

5.99. On 26 April 2017 the letter[29] from Duncan Lewis Solicitors Limited was sent to the Home Office:

Dear Sirs
NAME OF CLIENT: [D1527]
DOB: **DPA**
NATIONALITY Egyptian
HO REF [redacted]
We write on behalf of the above-named client, for whom we are already on record.

Serious Concerns about the welfare of our client

We have been informed that our client is currently on ACDT at on the Healthcare wing at IRC Brook House. He has expressed suicidal intentions to his support worker and stated that he is refusing food in an attempt to end his life. Our client has not eaten for 7 days and we have serious concerns that further detention will cause him serious injury or death.

We request that you urgently arrange for a Rule 35(1) Report to be carried out on our client to assess the effect of detention on his mental and physical health. Due to the deterioration in his mental health over the past 14 days, it is not sufficient for you to rely on him to approach detention centre staff himself to raise these concerns.

Furthermore, we request that the Rule 35(3) report, completed on 13"' April 2017 is re-assessed in light of the further evidence of the effect of detention on our client's health.

Use of Rule 40

Our client has informed us that he was removed from association yesterday, but he was not served with written reasons for this decision. We remind you that the Detention

[29] HOM000241 – Two letters from Duncan Lewis Solicitors to Immigration Enforcement re medical records/mental health issues of D1527, 26 and 27 April 2017

Centre Rule 2001 Rule 40 (6) states that detainees will be provided with written reasons within 2 hours of the decision.

We request that you immediately send us a copy of the reasons for using Rule 40. If no written reasons were produced, then please inform us of the action you intend to take against detention centre staff for unlawfully segregating our client.

[…]

- It is not clear whether the request made by solicitor was passed back to the healthcare team at Brook House for their further consideration of undertaking a Rule 35 (1) report.

5.100. On 27 April 2017 at 08:52 mental health nurse Karen Churcher recorded on SystmOne:

History Refusing food Day 6
Examination: Seen on wing.
Engaged despite being woken.
Does not feel like eating but is drinking tea and coffee with milk and sugar
Declined to have any physical observations completed.
Plan: BRAG rating Amber

5.101. On 27 April 2017 at 10:28 Dr Husein Oozeerally recorded on SystmOne:

History: Seen in E wing.
on ACDT.
He wishes to talk today and says to me that he is having difficulty sleeping though it is noted that he had to be awoken to have this conversation.
He says he has night mares at night and would like sleeping tablets.
He does not feel the current medication is helping
Plan: I have asked him to continue engagement with MHT and I have increased his dose of citalopram

- Dr Oozeerally prescribed citalopram 20 mg – two tablets daily (56 tablets)

- On this occasion, Dr Oozeerally increased the dose of citalopram to a total of 40 mg daily, which is the maximum dose.

5.102. On 27 April 2017 at 13:43 mental health nurse Karen Churcher recorded on SystmOne:

History: ACDT - Constant review
Examination: Seen on wing with Duty director M Brown, DCM D Rolley.
States he has no thoughts of self harm at this time.
Would like help to get a visit from his friend as they are having difficulty getting an answer when phoning.
M.Brown agreed to book this if details given to herself.
Would also like a new battery for his phone as old one no longer works after he put it in his mouth.
Keen to go back to general wing and association in centre.
Agreed he can have afternoon association until next review.
Plan: Observation levels reduced to hourly

5.103. On 27 April 2017 at 18:02 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Seen on wing. Playing pool, socialising and smiling with fellow detainees.
Gave the contact details of his friend to officer to help arrange a visit.
Requested that he be seen tomorrow as he was enjoying himself at the time, with his friends.
Plan: Support session to be rebooked for 28/4/17

- In view of the previous consultations, in which it was apparent that D1527 did not actively participate in the review appointments, it is useful to have this perspective on how he was interacting with other people within Brook House. For example, at least on this occasion it would have been reassuring to see that D1527 was socialising with others rather than isolating in his room on his own.

5.104. On 27 April 2017 the letter[30] from Duncan Lewis Solicitors Limited was sent to the Home Office:

> *Dear Sirs*
> *NAME OF CLIENT: [D1527]*
> *DOB:* **DPA**
> *NATIONALITY Egyptian*
> *HO REF [redacted]*
> *We write on behalf of the above-named client, for whom we are already on record. We have received and considered our client's medical records from IRC Brook House. The medical records indicate that our client has been informed by Healthcare staff he may not be released from detention due to his mental health issues. We believe that this is causing our client to significantly under-report the extent of his mental health problems because he is concerned that speaking honestly to Healthcare staff will prolong his detention. In particular, we refer you to a note made Nurse Karen Churcher on 21'" April 2017. She informed our client that:*
>
> > *Home Office have not released him despite receiving his rule 35. It was explained that often if there is a risk that he may harm himself they will not release as detention is a safer place for him. He than* [sic] *stated he just wants to die. Does not matter if in here, outside or in another country.*
>
> *We request that you urgently review the capacity of Healthcare staff at IRC Brook House to manage our client's complex mental health needs. In light of the comments of Nurse Churcher, we no longer consider that IRC Brook House offers care of sufficient quality to ensure that our client can be safely detained. We note that you have not responded to our correspondence sent yesterday, 26th April 2017, which requested the following:*
> *4 1. Disclosure of Rule 40 Notice;*
> *2. A Rule 35 (1) Report to review the effect of continued detention on our client's health.*

[30] HOM000241 – Two letters from Duncan Lewis Solicitors to Immigration Enforcement re medical records/mental health issues of D1527, 26 and 27 April 2017

[...]

- It is not clear whether the Home Office responded to the request made by **D1527's** solicitor or whether this was passed back to the healthcare team at Brook House for their further consideration.

5.105. On 28 April 2017 at 14:14 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Seen for review
Is now back to general wing and appeared more responsive and brighter in mood. Had just been to mosque.
Thinks that he has a visit on Wednesday from a friend.
Is not happy that he was not prescribed more sleeping medication. The rationale behind this and the increase of his
citalopram was discussed.
Plan: Follow up support appointment 5/5/17 at 3.30

5.106. On 28 April 2017 at 15:01 mental health nurse Karen Churcher recorded on SystmOne:

History: ACDT review
Examination: Seen in talking therapies with DCM S Farrell.
States that everything is fine and declined to elaborate.
Stating what ever you ask it is fine.
He has a new battery for his phone and is happy to be back on a normal wing.
Plan: Observation levels to continue on hourly and reviewed on 30/4/17

5.107. On 30 April 2017 at 09:10 nurse James Newlands recorded on SystmOne:

History Refusing food

Examination: Seen this morning on the wing to complete physical health checks on day 1 of refusing food. He declined to have any physical health checks done however said that the reason he was not eating is because he is
not hungry. States he is drinking fluids on a regular basis.
BRAG rating; Green
Plan: Continue to monitor as required.

5.108. On 30 April 2017 at 22:56 nurse June Watts recorded on SystmOne:

History Abdominal pain
Examination: 22.56Hr
Seen in D Wing as detainee c/o O/E - abdominal pain
Visited with nurse Grace
O/E
Detainee lying in the top bunk asked if he could get down so that we could assess him which he did with no obvious
signs of any mobility problems.
Claims he was getting some abdominal pain for the last hour
Claims no diarrhoea
No nausea or vomiting
Also states that the last few days he feels as if something is moving through his body and he claims he feels his
heart is beating fast.
Does not look unwell
No sweating
No pallor
Observations
137 / 98mmHg
P 85 regular and volume good
Sais 99% on RA
Temp37.4
Abdomen feels soft and he appeared quite relaxed at the time.
Bowel sounds a little quiet but heard
No obvious rebound pain noted

States he has just started eating today small amount only.
BNO for 5 days
As [D1527] *has a low grade fever we suggested Paracetamol and oral fluids.*
To attend healthcare in the morning or to be seen SOS

5.109. On 01 May 2017 at 10:02 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 2
Seen laying in bed, refused physical observation, refused to engage. Said he does not want to talk to me.
Brag Rating = Amber

5.110. On 01 May 2017 at 14:26 Dr Husein Oozeerally recorded on SystmOne:

History: Awoke this morning and coughed up blood.
This happened 5 days ago.
He says last night pain in the abdomen.
He says he is not eating due to apetite [sic], *he says he is is drinking.*
last passed urine yesterday. (unsure if blood in urine)
last opened 7 days.
Examination: chest clear.
abdo soft non tender.
alert
well perfused.
BS++ [bowel sounds present]
Plan: adv he must start to eat.
?citalopram on empty stomach causing problems.
consider PPI [proton-pump inhibitor] *if ongoing.*
O/E - pulse rhythm regular
Pulse rate 67 bpm
128 /70 mm Hg

5.111. On 02 May 2017 at 09:44 mental health nurse Karen Churcher recorded on SystmOne:

History Refusing food Day 3

Examination: Seen on wing.
States he ate some dates and drank fizzy drinks and water yesterday.
Declined to have his physical observations completed.
Plan: BRAG rating Amber

5.112. On 02 May 2017 at 14:41 mental health nurse Karen Churcher recorded on SystmOne:

History: Dr Belda. Seen at the mental health office with RMNs
Examination: Complains of vomiting blood (it seems ground coffee) and some abdmoninal [sic] *pain. He also complains*
of headaches and formication in his legs. His sleep pattern is disturbed as he keeps waking up through the night. His appetite is poor.
[D1527] *described clear intrusive memories and vivid imagery of the tragedy which he was the victim of. He has not spoken openly about it today.*
He explained that he came to the UK 3 years and 4 months ago seeking asylum and at the time he was 15 years old.
He said that he was sent to prison for an offence that he did not commit! and that eventually it was demonstrated that he was no guilty, but he was still sent here.
He does not feel that life is worth living and he has had 3 attempts on his life, 2 by hanging and 1 by cutting (?more self-harm than suicide).
[D1527] *could not identify any protective factors.*
Diagnosis: PTSD F43.1 [ICD-10 code for Post-traumatic stress disorder]. *He might also have hyponatremia* [low sodium level] *secondary to Citalopram (he is on 40mg of Citalopram a day which he says is not benefitting him). Citalopram could also increase bleeding.*
Plan: Recuce [sic] *Citalopram to 20mg and initiate Mirtazapine 15mg nocte. After 6 days stop Citalopram and increase*
Mirtazapine to 30mg nocte. Mirtazapine more appropriate for PTSD and his symptom profile. Blood test for U&Es [blood test for urea and electrolytes]
FBC [blood test for full blood count] *and coagulation profile. GP to be informed of his bleeding not clear if hematemesis as it could be due to ulcer*

- It is not entirely clear at what point concerns were raised by the mental health nurses that prompted this review by the psychiatrist and how long D1527 waited for this assessment.
- As a GP, it falls outside of my expertise to comment on the assessment and treatment provided by the psychiatrist.

5.113. On 02 May 2015 at 15:05 Dr Husein Oozeerally recorded on SystmOne:

History: Spoke to Karen C who has said we will be stopping citalopram ov [sic] *the next few weeks and starting mirtazapine.*
also BT [blood test] *to check Na* [sodium] *level*

- Dr Oozeerally prescribed mirtazapine 15 mg – 1 tablet daily (28 tablets) and citalopram 20 mg – 1 tablet daily (28 tablets).

5.114. On 03 May 2017 at 08:29 mental health nurse Karen Churcher recorded on SystmOne:

History Refusing food Day 4
Examination: Seen on wing.
States he ate bread yesterday and continues to drink regularly.
Declined to have his physical observations completed.
Plan: Brag rating Amber.

5.115. On 03 May 2017 at 08:40 healthcare assistant Eavan Owens recorded on SystmOne:

History: Came to clinic for blood test as requested by Dr Belda. I took venous blood after verbal consent was given.
Failed first time access from right arm at ACF [antecubital fossa] *site. Good first time access from left arm at ACF site. 1 x gold and 1 x*
purple bottle correctly labelled and sent to hospital. Detainee requesting for morning medication to be changed to
afternoon/evening. Admin task sent to doctor.

- The biochemistry blood test (gold bottle) taken on 03 May 2017 was reported on 04 May 2017 and reviewed on 09 May 2017. The results were normal and demonstrated that there was not a low sodium level as suspected by Dr Belda.
- I was not able to locate a copy of the full blood count results (purple bottle).

5.116. On 03 May 2017 at 09:57 Dr Oozeerally recorded on SystmOne:

- Mirtazapine 15mg orodispersible tablets - 6 tablets - 1 tablet - admin times: 19:45 (Oral)
- Mirtazapine 30mg orodispersible tablets - 28 tablets - 1 tablet - admin times: 19:45 (Oral) (Future dated medication 09 May 2017)

- The entry on this occasion reflects that Dr Oozeerally was made aware of Dr **Belda's** planned changes to D**1527's** medication and these were prescribed in keeping with this plan.

5.117. On 04 May 2017, there is video footage[3132] recorded by Mr Callum Tulley of the incident in which D1527 was on the netting.

5.118. On 04 May 2017 at 18:08 mental health nurse Karen Churcher recorded on SystmOne:

History: Healthcare
Examination: C&R [control and restraint] *removal from D to Ewing after coming off the netting, witnessed at 17.30.*
[D1527] *was eximined* [sic] *at 17.45.*
Has a small scratch on the inside of his left wrist. did not want a plaster and wound was not bleeding.
Stated he was O.K.
Form 213 completed, given to Oscar 1 and safer community [sic]

[31] BBC000091 – KENCOV1012 – V2017050400021 – 04 May 2017: 17:45-29:59, TRN0000004
[32] BBC000091 – KENCOV1012 – V2017050400022 – 04 May 2017: 00:00-09:09, TRN0000006

5.119. On 04 May 2017 at 22:38 nurse Nombulelo Sihlali recorded on SystmOne:

History: 22.25hrs called by oscar 1 Andy to review constant, spoken to detainee and is no longer on on constant
Examination: Remaine [sic] *on R 40 and is happy in wing advised if he has any issues to mspeak* [sic] *to officers and not to*
jump to the net again which he understand.

5.120. On 05 May 2017 at 09:09 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History Refusing food (Ongoing Episode)Day 5
[D1527] *was awake in bed when visited following food refusal referral. Refused physical observation, declined to*
say when he had last drank.
Brag Rating = Amber

5.121. On 05 May 2017 at 19:52 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History: Did not attend his mental health appointment, was later seen socialising with friends opposite the barber shop on A wing. Further appointment given for the 13/05/17 at 11:00 slip has been sent.

5.122. On 06 May 2017 at 08:31 mental health nurse Karen Churcher recorded on SystmOne:

History: Refusing food (Ongoing Episode) Day 7
Examination: Seen on wing.
Documented and states he ate and drank yesterday.
Declined to have his physical observations completed.
Plan: BRAG rating Green

5.123. On 07 May 2017 at 13:51 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 7
Seen on C wing this morning following food refusal referral. Was laying awake in bed, refused physical observation.
Said "everything is OK", refused to engage further.

Brag Rating = Amber

5.124. On 08 May 2017 at 17:23 mental health nurse Karen Churcher recorded on SystmOne:

History: ACDT review
Examination: Seen in talking therapies with DCM B Shadbolt.
States he has no current thoughts to self harm and is happy now that he is off of E Wing.
Is waiting to hear from Home office about an appeal his solicitor has put in.
Is still having problems sleeping. Encouraged not to sleep during the day and keep himself busy.
Plan: Observation levles [sic] *to continue and review on11/5/17*

5.125. On 08 May 2017 at 17:28 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Requested to see RMN after ACDT review.
Feels he is having problems with anger. Gets angry very quickly and sometimes it feels as if he is on the outside looking down on himself.
Tried to show diagramnes [sic] *regarding how anger effects us but is unable to read.*
Also feels that his flashbacks happen for no reason and wanted to understand why.
Explored possible triggers.
Session had to be cut short as this was not a booked session and next person was waiting.
Plan: Follow up appointment made for made for 13/5/17

5.126. On 09 May 2017 at 09;15 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History Refusing food (New Episode) Day 1
Seen laying awake in bed, refused physical observation. He also refused to say when he has last drank fluid,
However, an empty water bottle was seen on the table by his bedside. Said "I am fine".
Brag Rating = Amber

5.127. On 10 May 2017 at 01:21 nurse Nombulelo Sihlali recorded on SystmOne:

History: 01.35hrs called to wing to see detainee, on arrival was sitting In bed looks low In mood
Examination: According to him he had a dream and saw a freind covered in blood.
Diagnosis: Also stating that he has flash back of what he has done before .Has no thought of self harm, he also
stated that sleeping tablet is not effective, advised to come to walk in clinic to make an appointment for m/o
Plan: To be seen again by RMN today

5.128. On 10 May 2017 at 11:10 nurse Ayesha Mataraarachchi recorded on SystmOne:

History: detainee came to asked his blood results are available it is available given him to come and see doctor he said he still got symptoms still having cough and heavy runny nose and head ache given him an appooinment [sic] *tempreture* [sic] *afebrile* [sic] *respiration 16/BPM he said night nurse promise him that RMN will see him today spoke to RMN she said he already got appoinment on the 13/5 he know about that as he got slip and she*
cannot see him today as she was fully booked

5.129. On 11 May 2017 at 08:26 nurse James Newlands recorded on SystmOne:

History Refusing food (New Episode)
Examination: Seen this morning on Day 1 of refusing food to complete physical health checks, however did not wish to engage in conversation or have any physical health checks done. He did say that he was drinking on a regular basis.
BRAG rating; Green
Plan: Continue to monitor as required.

5.130. On 12 May 207 at 09:23 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 2
Seen laying in bed awake, refused physical observation. He also refused to say when he had last eaten or drank.
Brag Rating = Amber

5.131. On 14 May 2017 mental health referral form[33] was completed by Miss Nana-Yaa Dankwaa-Akowuah:

Detainee requesting to RMN input. Referral made of the request of Dr. Chaudhury

5.132. On 14 May 2017 at 08:29 nurse James Newlands recorded on SystmOne:

History Refusing food (Ongoing Episode)
Examination: Seen this morning to complete physical health checks on Day 4 of refusing to eat.
However he did not wish to engage in conversation with me or allow any physical health checks to be done.
BRAG rating; Amber.
Plan: Continue to monitor as required.

5.133. On 15 May 2017 at 08:39 nurse James Newlands recorded on SystmOne:

History Refusing food (Ongoing Episode)
Examination: Seen this morning on C wing to complete physical health checks on day 6 of refusing food. Informed me that he was okay however did not want any physical health checks to be done
BRAG rating; Amber
Plan: Continue to monitor as required.

5.134. On 16 May 2017 at 09:39 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 6 as stated on Security Handover.
Was laying awake in bed, Refused to have physical observation done, Said "I am fine, don't worry".
Brag Rating = Amber.

5.135. On 16 May 2017 at 11:50 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History: Retrospect;

[33] CJS001122 – G4S Health Mental Health Referral Form for D1527, dated 14/5/17

Did not attend his mental health review appointment 13/05/17, another appointment has been given for the 17/05/17
at 16:30. Slip was sent.

5.136. On 17 May 2017 at 08:43 mental health nurse Karen Churcher recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 7
Examination: Seen on wing.
States he did not eat yesterday but did drink water. Not feeling like eating but said he would try today.
Declined to have his physical observations completed.
Plan: BRAG rating Amber

5.137. On 17 May 2017 at 09:24 mental health nurse Karen Churcher recorded on SystmOne:

History: ACDT review
Examination: Seen in talking therapies with DCM C Donnelly.
Refused to state if he had eaten or not.
States he does not want to apply for bail now and wishes to spend his life at Brook house.
Declined to have his physical observations completed again.
Plan: Observation levels decreased to mealtime observations during the day and 2 observations at night.
Review in a weeks time.

5.138. On 17 May 2017 at 16:28 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Seen for follow up session.
Ventilated at length about his detention, his thoughts and feelings.
Expressed concern regarding his anger and how quickly he can be provoked.
Feels that the medication is not helping. Discussed the reason it was changed and looked at possible increase in Mirtazapine to help with his mood.
Feels that detention is making him mentally unwell. reassured that he is under stress and that this is a normal reaction.

Requested GP increase medication.
Plan: Follow up appointment booked for 20/5/17 at 16.30

5.139. On 18 May 2017 at 09:23 nurse Dahlia Mcaught-Dowd recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 7
Was awake in bed when seen on C wing , declined physical observation. Said "I am fine, thank you". Claims he has been drinking fluid.
Brag Rating = Amber

5.140. On 18 May 2017 at 10:13 Dr Saeed Chaudhary prescribed on SystmOne:

- Mirtazapine 45mg orodispersible tablets - 28 tablets - 1 tablet - admin times 1945 (Oral)

➢ The entry by Dr Chaudhary on this occasion reflects the request for an increase in the dose of mirtazapine made by D1527 on the preceding day.

5.141. On 19 May 2017 at 09:33 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 8
Was awake in bed, declines physical observation. Said he ate chocolate and drank juice on the 18/05/17.
He was educated about the importance of him eating and drinking.
Brag Rating = Amber.

5.142. On 20 May 2017 at 09:02 mental health nurse Karen Churcher recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 9
Examination: Seen on wing. was not happy as had just had an officer coming to ask him the same questions.
Therefore he declined to answer the questions and declined to have his physical observations completed.
Plan: BRAG rating Amber

5.143. On 20 May 2017 at 09:44 staff nurse Melissa Morley recorded on SystmOne:

History: c/o blood in mouth when waking, states ongoing issue since his hospital admission.
Asked for blood test results. Advised all results have come back in the normal range.
Doctor appt booked.

5.144. On 20 May 2017 at 17:19 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Did not attend his mental health appointment.
No reason given.
Plan: Further appointment offered for 21/5/17 at 11:30

5.145. On 21 May 2017 at 08:24 nurse James Newlands recorded on SystmOne:

History Refusing food (Ongoing Episode)

Examination: Seen this morning on C wing to complete physical health checks on day 10 of refusing food. He declined to have these done stating that he was okay and well.
BRAG raing; Amber
Plan: Continue to monitor as required.

5.146. On 21 May 2017 at 11:31 nurse James Newlands recorded on SystmOne:

History: RMN appointment
Examination: Did not attend with no reason given.
Plan: New appointment arranged for 28/05/2017 at 11:00, appointment slip sent to the wing.

5.147. On 22 May 2017 at 08:28 nurse James Newlands recorded on SystmOne:

History Refusing food (Ongoing Episode)
Examination: Seen this morning to complete physical health checks on day 11 of food refusal. Declined to have these done and said that he did not want healthcare to come into his room about this. Advised that as long as he was refusing to eat we had a duty of care to offer him physical health checks whether he accept to have these done

was his decision.
Plan: Continue to monitor as required

- This entry and a number of those preceding this point in time demonstrate the challenges with being able to offer observation and assessment of a person who has the capacity to refuse intervention, declines consent to having any physical checks.
- It is also important to highlight that accurate and detailed observations of a **person's** food and/or fluid intake in this setting can be very difficult. Precise amounts of fluid and/or food intake may not be readily recordable if there are numerous sources from which the person can obtain supplies.

5.148. On 23 May 2017 at 08:16 nurse James Newlands recorded on SystmOne:

History Refusing food (Ongoing Episode)
Examination: Seen on the wing this morning to complete physical health check which he refused to have done and did not want to engage in conversation with me.
BRAG rating; Amber
Plan: Continue to monitor as required.

5.149. On 23 May 2017 at 12:50 Dr Husein Oozeerally recorded on SystmOne:

History: Attended C wing to speak to patient with HCA Eavan
Food and fluid refusal.
We asked if we could enter to room and he said he did not want us to enter.
We were unable therefore to engage regard advanced directive.

5.150. On 24 May 2017 at 09:06 mental health nurse Karen Churcher recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 14
Examination: Seen on wing. Declined to engage. Hand visible, waving me away.
Unable to gain consent for physical observations to be completed.
Plan: BRAG rating Amber

5.151. On 24 May 2017 at 14:55 recorded on SystmOne:

Did not attend for GP1 appointment with Brook House Doctor.

5.152. On 25 May 2017 at 08:16 mental health nurse Skeete Jitta recorded on SystmOne:

Overview Notes - Recorded as declined
Overview Notes
Attended Room 208 on C Wing with the aim of conducting the food/fluid assessment. However, [D1527] *declined intervention, said he did not want to see healthcare*

5.153. On 25 May 2017 at 08:38 mental health nurse Skeete Jitta recorded on SystmOne:

Overview Notes - Due to [D1527] *recorded as being on food/fluid refusal for 15 days it was advised that a supported living plan is activated to identify and provide assitional* [sic] *support, however he declined to engage*
Overview Notes - Informed practice manager Wells that [D1527] *had declined to engage, was advised*
that the plan could not be opened if he had declined to engage

5.154. On 25 May 2017 at 12:30 Dr Saeed Chaudhary recorded on SystmOne:

History: Went to C wing to do Advanced directive, Home office present. pt not in room, put call out and patient not responded. Agreed to try again tomorrow.

- An Advanced Directive (Decision) is is a statement of instructions about what medical and healthcare treatment a person may want or not want in the event that they have lost the mental capacity to make these decisions.
- Given **D1527's** ongoing and apparent refusal of food, it would have been of significant concern to the healthcare staff that at some stage, this refusal would lead to a deterioration in his condition.

- It is well recognised that with prolonged food and fluid refusal that this can have an impact on the mental capacity of the individual and that at some stage, mental capacity for making decisions about their health can be lost.
- If there is no Advanced Decision in place, then healthcare staff must act in a **person's** best interest if they are of the view that the person has lost mental capacity.

5.155. On 26 May 2017 at 08:57 staff nurse Anne Herbert recorded on SystmOne:

History Refusing food (Ongoing Episode)
Examination: Seen on the wing in the company of an officer.
He initially sat up in bed, however on introduction, he laid himself back down into bed and declined any interventions.
Therefore, unable to fully assess.
BRAG Amber.

5.156. On 27 May 2017 at 08:44 mental health nurse Karen Churcher recorded on SystmOne:

History Refusing food (Ongoing Episode) Day 17
Examination: Seen on wing. Ate dinner last night and took his Ramadan box.
Declined to have his physical observations completed.
Plan: BRAG rating Green

5.157. On 27 May 2017 IS.91RA Part C: Supplementary Information to IS.91 RA Part A[34]

Detainee [D1527] *ACDT has been closed, currently eating and no thoughts of self harm*

5.158. On 27 May 2017 at 22:45 nurse Nombulelo Sihlali recorded on SystmOne:

History: 22.15hrs went to give him his medication, when I arrived he was still praying. Examination: I explained to his freind that i should give his medication and he is ment to finish to pray Diagnosis: When he finished to pray he started shouting and telling

[34] CJS001073 – IS.91RA Part C: Supplementary Information to IS.91 RA Part A dated 27.05.2017

me that i should go to other detainees and come back or i should leave his medication sothat he can take them later
Plan: I explained that by 21,45hrs i should start the medication and after 22.00hrs he should have finished praying
and i explained to him that other detainees are also waiting which he stated that he does not care and i mexplained [sic]
to him i wont wait for him after 22.00hrs to finish praying he was very rude.

5.159. On 02 June 2017 at 15:37 mental health nurse Karen Churcher recorded on SystmOne:

History: RMN
Examination: Did not attend his mental health appointment.
This is the forth [sic] *appointment not attended therefore discharged from case load.*
Plan: To self refer if required [sic].

5.160. On 12 June 2017 at 16:56 nurse James Newlands recorded on SystmOne:

History: RMN
Examination: Requested an appointment which was made for today, slip was given to [D1527].
However did not attend his appointment.
Plan: No further appointments have been made.

- These and some of the preceding entries demonstrate the difficulty with finding the right balance between making a service available for a person whilst allowing them to take responsibility for their own follow-up and treatment.

5.161. On 13 June 2017 at 18:51 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History: Saw [D1527] *following request from M. Wells (Practice Manager), Pleasant and appropriate on approach.*
He was orientated to time, date and place. He appears calm and settled in his mental state.

He complained that he is tired of being here and he want to be release. Said he has been waiting on Immigration for the past 3 months and he is still here, he further complained that his mind is always busy, his concentration is poor and he is forgetful. He did not appears to be suffering from poor concentration at the time of his appointment. h

he was paying close attention to questions asked and was communicating effectively. Did not appears to be suffering from any thought disorder, psychotic or depressive disorder.

His main concern at to time was that he want to be release, said "my main problem is that I want to be get out of here", "I want to be release because I have never been good here"

Said Immigration had asked him to sign for them to get access to his medical record, was questioning me as to whether I think he should have sign or not. He was told that I couldn't give him an answer so he is to talk to his solicitor about same. Said he has already done so.

Said he gets on well with other detainee, but sometimes he rather stay inside his room. Confirmed he has been eating and drinking, but his appetite fluctuates. Currently on Ramadan.

Denies suicidal thought and self harm ideation.

Said he will return to healthcare whenever he need to see a mental health nurse

5.162. In summary, this case study involves a 23 year-old detained person who was received directly from the prison system into Brook House on 04 April 2017 and who was already on ACCT document because of his identified risk of self-harm and suicide prior to his arrival.

5.163. In the subsequent two-month period D1527 had close involvement of the mental health team because of his ongoing plans to self-harm. This appeared to be in response to the prospect of deportation and/or the frustration with ongoing detention. D1527 was seen to resort to periods of food and/or fluid refusal, concerted indiscipline and acts of self-harm

and was continued on the ACDT process throughout the majority of his stay within Brook House.

5.164. A Rule 35 (3) report was carried out by the GP within ten days of **D1527's** arrival in Brook House. However, the response from the Home Office concluded that detention should be continued.

5.165. On 25 April 2017 D1527 was subjected to a Use of Force in response to an act of apparent self-harm by a member of the custodial staff in which an apparently unjustified and inappropriate technique was used which appeared to be indicative of strangulation. In my opinion, the nurse who was present during the Use of Force apparently failed to recognise and/or intervene in regard to the inappropriate technique and in doing so, lacked regard for the welfare of D1527 during this incident. This is a preliminary view based on the material provided to date and until such time that I receive further evidence that assists in providing further perspectives on this incident.

Case D687

5.166. In summary, this case relates to a DPA year-old gentleman of Somalian origin who was received into Brook House on 29 October 2015.

5.167. On 04 June 2016 at 15:53 mental health nurse Skeete Jitta recorded on SystmOne[35]:

Overview Notes - On arrival, saw [D687]*, sitting on his bed, no evidence of being in discomfort, he stood up no indication to suggest unsteadiness, said he was fine, oscar 1 was speaking with him,* [name of roommate?] *said he was fine and did not want to be seen by the healthcare, Not able to assess further, Overview Notes Y0028 - called to Code Blue on C -204*

5.168. On 04 June 2016 at 16:16 staff nurse Mila Pagud recorded on SystmOne:

History: 15:45 1st Response Call - Code Blue
Examination Attended 1st response call to C Wing, 204 ? Spice. det. found standing talking to Osca 1 and other
Officer, coherent, responsive, no difficulty of breathing noted. Refused to be seen by Health care Staff. His roommate said he will keep an eye on him and will call us an abnormalities noted.

- In summary, the entries indicate the suspected use of a psychoactive substance.

5.169. On 18 August 2016 at 15:37 social care support worker Caroline Hampshire recorded on SystmOne:

Referral received from Security regarding concerns around Substance Misuse, a letter has been sent to [D687] *inviting him to engage with the Service on the 7th July 2016.*

[35] CJS001139 – G4S Gatwick IRCs D687's Medical Records, 28 April 2020

No engagement as yet (18th August)

5.170. On 26 September 2016 at 15:50 Ms Pamela Bowers recorded on SystmOne:

1-1 session with [D687]*, really motivated to stay clean, agreed to collect course work from Reception, to remind himself of drug work completed.*
Wants to attend AA meetings

- In summary, the entries indicate the attempt to follow-up D687 following on from his suspected use of a psychoactive substance.

5.171. On 23 October 2016 at 09:07 nurse James Newlands recorded on SystmOne:

History: Refusing food
Examination: Seen this morning on A wing to complete physical health checks regarding food refusal. When I saw him in his room he was lying in his bed. He became verbally aggressive and shouted at me to get out of his room and did not wish to be seen by healthcare.
Plan: To continue to try and complete physical health checks whilst he is refusing to eat.

5.172. On 07 March 2017 at 18:30 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History: Very tearful and anxious as he ventilates his feeling, troubles and concerns, [D687] *reports that he came to the UK at the age of 8 years after his family and him flee from Somalia Land because of war. Said both him and his family was granted asylum and were given and indefinite leave to remain. Disclosed that he was* [redacted] *but now without a vast amount of support and encouragement as he was reluctant to do say. Very hesitant to disclose that he was* [redacted]
Said he has been a troubled child since his ordeal and did not find to courage to said it to anyone because of being ashamed and afraid. Says the ways he choose to cope/deal with his experience wasn't the right way, but he was not aware of this until it was too late. Because it got has got him into trouble several times, said one day he called the police and told them about all the crimes he had committed [redacted]

because he wanted to come clean and turn a new page in his life. Was given [redacted] *but this was reduced* [redacted] *because of being honest and leniency from the judge and police. worries that he might be deported to Somali, said he is from Somali Land and not Somali where Immigration is planning to deport him. Claimed he does not have any family in Somali or Somali Land son he cannot return.*

Said he has been trying to get over his feelings and the impact of [redacted], *but nothing was helping, Said he was afraid to talking to anyone about his experience and this was the reason why he did not attend his previous mental health appointment. Reports that ge gets to realised that bottling up his feeling does not help, said he is not a person that hoes around and make trouble, but sometimes he is stress and does not know how to talk to anyone or who to talk to about his problem. He was reassured that whatever he has disclosed will not be passed on to any one without his consent, he was informed that healthcare staff will have access to his record but will remain confidential except for information that will put his life or other detainees life at risk at risk.*

The support and reassurance that was given appears to have a positive effect on [D687] *he said he felt as if the load he was carrying on his shoulders has decrease. Managed to ventilate in length with support. Said he wanted to talk to someone about his problem and to be a better person, says that is why he he was searching for help. Confirms he is eating and drinking, said he finds it hard to sleep sometimes, but he tries to go to the gym as this helps sometimes.*

Denied suicidal thoughts and self harm ideation.

Plan: 1, To attend the art and craft class.

2, Will contact Sabastian re the Victim Awareness group.

3, [D687] *confirmes he will speak to and officer whenever he cannot cope with his current situation.*

4, To keep in contact with his solicitor and to seek help whenever he need it.

- In summary, this entry appears to indicate the first disclosure within Brook House IRC of his reported past history of trauma.

5.173. On 14 March 2017 at 13:36 nurse James Newlands recorded on SystmOne:

History: RMN appointment
Examination: Did not attend with no reason given.
Plan: New appointment arranged for 20/03/2017 at 14:30 appointment slip sent to the wing

5.174. On 20 March 2017 at 14:39 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Did not attend his mental health appointment with no reason given.
This is 2nd appointment not attended. A furher appointment to be offered with a view to discharge if DNA.
Plan: Follow up appointment booked for 22/3/17 at 4.30 pm

5.175. On 22 March 2017 at 16:38 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Did not attend his mental health appointment.
No reason given.
This is 3rd appointment not attended, therefore he has been discharged from Mental health services.
Plan: Dischrged, to self refer if required.

5.176. On 11 April 2017 at 12:11 Mr Anton Bole recorded on SystmOne:

Substance misuse team - Received referral from Security that [redacted] *was using Spice.* [redacted] *stated it was only once due to stress. Referral has been made to Gatwick Detainees Welfare group. 1:1 session on Harm*
Minimisation completed. Lower tolerance and overdose risks advice given to [D687].
Spice use Care Plan Created
Spice use Review next due on 11 May 2017 12:14
Spice use Review next due on 18 A r 2017 12:14

5.177. On 13 April 2017 at 14:54 staff nurse Lyn **O'Doherty** recorded on SystmOne:

History: Came to healthcare with DCO & Oscar-he had been given some negative news from H.O and got angry and
frustrated on wing. As a result sustained a small graze to right inner aspect of arm
Examination: Cleaned & mepore applied
Plan: Angry and upset-given time to vent his feelings before returning to association

5.178. On 13 April 2017 at 16:13 staff nurse Lyn **O'Doherty** recorded on SystmOne:

History: Returned to clinic via Welfare requesting Rule 35
Plan: Became tearful talking about what happened to him in Somalia- [redacted]. *(see RMN entry). Booked for MO.*
Practises deep breathing techniques. Also suggested to attend sleep/relaxation group

5.179. On 15 April 2017 at 10:42 Dr Husein Oozeerally recorded on SystmOne:

History R35
He claims to have been abused [redacted] *in Somalia, in* **DPA** .[redacted]. *He remembers that his family and extended family escaped to a camp in* **DPA** [redacted]. *He claims to never have disclosed this. He was not previously known to mental health services. He later discloses that he almost jumped from a bridge but some friends passing by discouraged him. He mentions that in the last 3 months, he has started hearing voices and gets very stressed and emotional. He also he had difficulty sleeping and is very concerned about being deported. He appears tearful on presentation. He is not on antidepressants but remains under the care of the Mental health team.*
Plan: He will attend at 1330 to sign consent
Clinical Letter to [D687]

- In summary, this entry corresponds with the Rule 35 (3) report completed by Dr Oozeerally.

5.180. On 15 April 2017 the Rule 35 (3) Annex C report[36] completed by Dr Husein Oozeerally concluded:

[36] CJS00848 – Home Office Rule 35(3) Report dated 15.4.2017

He does not have any scars relating to the account but this is consistent with the account He describes a traumatic event [redacted]. I am unable to comment on prolonged detention effects or credibility of account.

- In summary, it is of note that Dr Oozeerally makes specific reference to being unable to comment on the impact of detention or whether the account provided to him was credible.

5.181. On 26 April 2017 correspondence[37] was received from the Home Office:

I am writing to you to confirm we have considered the report dated 15 April 2017 provided by the medical practitioner at IRC Brook House, notifying us of a special illness or condition. Information contained within the report has been considered and the decision to detain you has been reviewed.

…

In relation to your claim of ill-treatment, your account of ill-treatment does meet the above definition of torture. Accordingly, it is accepted that the evidence provided meets Level 2 and as such, you are regarded as an Adult at Risk under the policy. Your detention has been reviewed and the report considered when determining your suitability for detention under the 'Adult at Risk' policy.

Immigration Factors

You arrived in the United Kingdom at Heathrow Airport on 2 November 1994 with your siblings as a dependant of your mother on a family reunion visa issued in Addis Ababa, Ethiopia on 20 September 1994. On 25 September 1997, you were granted Indefinite Leave to Remain as a refugee, as a dependant of your mother.

Following your conviction on [redacted] *you were considered for deportation action. However, on 22 November 2012, the Director had approved the submission proposing to cease deportation action against you on the grounds of a breach of Article 3.*

[37] HOM000013 – Home Office response to Rule 35 (3) report dated 26.04.2017

On 23 November 2012, you were released from detention. However, you reoffended and following your conviction on [redacted], *you were served with your Notice of liability to deportation questionnaire (ICD.0350AD).*
On 20 March 2015 you were detained under Immigration powers.
On 30 July 2015, your refugee status was ceased.
On 14 August 2015 deportation was signed and it was served on 19 August 2015.
On 26 August 2015, appeal was lodge against decision to deport you. Your appeal was dismissed on 29 June 2016. Your permission to appeal to the Upper Tier was refused on 9 September 2016 and subsequently you became appeal rights exhausted.
On 2 March 2017, you submitted further Asylum based representation which was considered and refused on 15 March 2017 without an in country right of appeal then your case was added to a pool of cases awaiting enforced removal to Somalia.

Public Protection Factors
On [redacted] *you were convicted for* [redacted] *to 3 years' imprisonment on* [redacted]. *You were also required to pay a victim surcharge of* [redacted]. *You did not lodge an appeal against the sentence or conviction.*
Between [redacted], *you were convicted 15 times for 25 offences including*, [redacted].
You are subject of a signed Deportation Order.

Balancing risk factors against immigration control factors
Careful consideration has been given to balancing the need to promote your wellbeing whilst in detention against the risks of harm to the public and the need to maintain effective Immigration control. Your detention is considered proportionate to your circumstances, particularly taking into account your immigration history and criminal record. Although you entered the UK with valid leave, your refugee status was ceased on [redacted] following your conviction on [redacted]. You currently do not have any valid leave in the UK therefore you are not entitled to take up employment or access to claim any benefits. Therefore you would have no means of supporting yourself and it will be highly unlikely that you will comply with any release conditions. Furthermore, it has been noted that you have been refused IAC bail as recently as [redacted] and the presiding Judge highlighted the risks of absconding and of reoffending in his remarks as follows:

"(i) The appellant, subject to a deportation order, has exhausted all rights of appeal He does not have on foot any application and the respondent is endeavouring with expedition to deport him to Somalia. In IS.335 evidence the applicant emphasised his determination to remain in the UK. The applicant has little incentive to surrender to bail and presents a distinct absconding risk.

(ii) The applicant poses a real risk of harm to the public"

You are a persistent offender who has committed 25 offences and your pattern of behaviour demonstrates a potential risk of harm to the public. It is considered that you pose a risk of absconding and reoffending if released. In light of all these factors, it is considered unlikely that you would leave the UK voluntarily if released and that you would be unlikely to comply with any restrictions placed upon you. Although it is accepted that you are an Adult at Risk, the Doctor has not indicated that a period of detention is likely to worsen your symptoms. You have been assessed as fit to travel and there are currently no barriers to your return. You can be removed to Somalia on an EU letter and your removal is expected to be undertaken within the next 8 weeks

Conclusion

It is acknowledged that you are an Adult at Risk but it is considered that your removal can be enforced within a reasonable timescale. Therefore when balancing the indicators of vulnerability against the negative immigration factors highlighted above and the timescale for your removal, it is considered that the negative factors outweigh the risks in your particular circumstances. Therefore a decision has been made to maintain your detention.

- In summary, it is of note that although the Home Office case worker considered that the material provided within the Rule 35 (3) report met the Level 2 Adults at Risk threshold, there was no determination by the doctor completing the report that ongoing detention was having a negative impact on D687.
- In my opinion, there was sufficient evidence within the SystmOne records that **D687's** mental health was deteriorating but this has not been accounted for within the Rule 35 (3) report and therefore the Home Office case worker has not been able to take this

into consideration. Equally, in the absence of any reference to the impact of ongoing detention on D687 by Dr Oozeerally completing the report, the case worker does not appear to have gone back to the doctor in order to request clarification on this specific point.

5.182. On 05 May 2017 at 14:00 substance misuse worker completed a Security Information Report[38]:

[D687] *approached myself whilst I was completing my duties.* [D687] *stated he was feeling really low, and has had enough of being detained for so long. Stated he will overdose. I have reassurance to* [D687] *and advised him to continue fighting his case and not to give up. Reminded him detention is not forever and however frustrated he is to stay focused, to get himself out of detention. Slight concern of low mood.*

5.183. On 05 May 2017 at 19:08 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History: Went to A wing to see [D687] *following call received from Oscar 1who reported that he was informed that* [D687] *told a Mr Bole (RAPT) that he is going to take an overdose. He had just finished serving dinner on B wing when seen. Reports that he had enough because he has been in detention for too long. Was commended for making his thought/ideation known, support and reassurance was given, Encouraged to seek help whenever felt things are getting too much and to stay positive.*
healthcare staff were informed in handover.
Plan: Mental health review/support on the 08/05/17 at 16:30.

5.184. On 05 May 2017 Care of At Risk Detainees ACDT Plan[39] was commenced:

Frustration with Immigration [Page 4]

5.185. On 05 May 2017 IS 91 RA Part C: Supplementary information:

[38] CJS004810 – Detention services security information report re D687 05.05.17
[39] CJS000993 – Care of at Risk Detainee ACDT Plan for D687 dated 5/3/2017. Ongoing record 10/05/2017 - 13/05/2017

ACDT opened on [D687] *as he has made threats to take an overdose to the RAPT team. Brook House mental health team aware.*

5.186. On 08 May 2017 at 16:41 mental health nurse Karen Churcher recorded on SystmOne:

History RMN
Examination: Seen for follow up appointment.
Is finding being detained harder and harder to deal with. Feels it is now impacting on his mental health.
Keeps himself active during the day. Has a job and participates in several activities but at night cannot escape from his thoughts.
Is scared about returning to Somalia where he does not know anyone and is frustrated at being detained.
Sometimes gets angry for no reason
Having problems sleeping, reads to help with this.
Allowed to ventilate his thought and feelings.
Discussed the possibility of a mild anti depressant.
GP appointment booked for 10/5/17 to discuss.
Feels talking helps.
Plan GP appointment booked for 10/5/17
Follow up support session booked for 16/5/17 at 11 am

5.187. On 10 May 2017 at 15:05 there is an entry recorded in SystmOne:

Did not attend for GP1 appointment with Brook House Doctor.

5.188. On 11 May 2017 10:22 nurse Donna Batchelor recorded on SystmOne:

History: came in after missing appointment
booked by RM N
Plan: M/O appointment rebooked

5.189. On 13 May 2017 at 13:30 there is an entry recorded on SystmOne:

Did not attend for GP Appointments appointment with Brook House Doctor.

5.190. On 13 May 2017 video footage[40][41] shows an incident:

At 02:40 detainee is seen sitting on the edge of a toilet seat with a piece of material attached to a handle and looped around his neck. It is not tight and he is talking freely stating he has "**had enough**". A long discussion ensues in which he explains his frustrations. The detained person is obviously angry and frustrated about a number of issues and the length of time in detention. At 06:38 stated that the "**Dr** took the **piss**". At 13:35, the detained person rises to stand and the officers engage to physically restrain him. At 14:08 "**Ligature** is **away**". at 16:02, officers are assisting the detainee to stand. At 18:07, healthcare staff appear and at 20:00 the nurse asks if she can review the detained person after use of force and if there are any "**healthcare issues**".

5.191. On 13 May 2017 the SystmOne records contain an F213:

Minimal force used. Refused to show hands/arms, slight red mark neck, no other physical health issues [illegible] *seen.*

5.192. On 13 May 2017 Use of Force form DCF2[42] was completed:

- In summary, this is a 28 page document containing statements from Daniel Haughton, Andy Donnelly, Shane Farrell, Johnny Martin and Callum Tulley in relation to the use of form to prevent self-harm and in order to facilitate the impending transfer to another IRC.

5.193. On 13 May 2017 IS 91 RA Part C: Supplementary information[43]:

[D687] *left Brook House on open ACDT for the Venue IRC. Force required (spontaneous) to effect the suitable crew move.* [D687] *had placed a ligature round his neck in the discharge waiting room toilet to prevent his move. ACDT reviewed - 4 obs per hour pending review on arrival at the Verne*

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[40] BBC000070 – KENCOV1016 – V2017051300011 02:05 – 30:00, TRN0000095 (pages 33-39)
[41] BBC000070 – KENCOV1016 – V2017051300012 00:00 – 02:24, TRN0000095 (pages 41-42)
[42] CJS005652 – G4S Use of Force DC Rule 41 relating to D687 force used on 13.05.17 at 13:54
[43] CJS000993 – Care of at Risk Detainee ACDT Plan for D687 dated 5/3/2017

5.194. On 13 May 2017 Self Harm Incident Investigation form[44]:

Whilst waiting in the discharge waiting room [D687] *decided he did not wish to transfer to IRC Verne and whilst sitting on the toilet tied his t shirt loosely around his neck and to the disabled grab rail next to the toilet and refused to move. He was offered a light for his cigarette by the Duty Director Dan Haughton and as he leaned forward to light the cigarette the Duty Director grabbed the knot on the grab rail,* [D687] *then dropped to the floor and the ligature came loose and fell off. Minimal force was used to present* [D687] *to the awaiting Tascor escorts. Would not show hands or arms, slight red mark observed on neck. - Healthcare were informed by one of the officers present.*

- In summary, this document contains a series of statements from Shane Farrell, Dan Haughton in regard to the use of force required to transfer D687 into the custody of Tascor in order to transfer to The Verne.

5.195. In summary, the records provided demonstrate the case of a detained person who was in Brook House between October 2015 and May 2017 before transfer to IRC The Verne, a period of approximately 19 months. During this period, there appears to be initial issues relating to the use of psychoactive substance followed by a disclosure relating to past traumatic experiences in March 2017. There were attempts to engage D687 with the mental health and substance misuse teams. Following **D687's** disclosure of past traumatic experiences and the completion of a Rule 35 (3) report by Dr Oozeerally, the Home Office case worker considered the evidence and wrote to confirm that detention would be maintained. This decision appeared to result in increasing frustration with D687 threatening to take an overdose and an ACDT being commenced.

[44] CJS001084 – D687 Self harm incident investigation dated 13.5.17

5.196. From a medical perspective, it is understandable that following a self-declaration of past traumatic experiences as referred to by D687 and with the expectation that there would be support and understanding by the healthcare team, that to have this rejected by the Home Office would be perceived negatively by the detained person and extinguish any remaining hope of being released from detention.

5.197. It is also noted that D687 also '**did** not **attend**' a number of appointments with the mental health team and the GP. This appears to be a common issue and it is not clear from the records what the factors are that influence whether or not someone is likely to attend for their appointments. Equally, it should also be accepted that a level of responsibility for attending their appointments must rest with the detained persons and that understandably, this can be a difficult balance to strike.

Case D720

5.198. In summary, this case relates to a DPA year-old gentleman of Grenadian origin who was received into Brook House Immigration Removal centre on 28 March 2017.

5.199. On 25 March 2017 at 03:21 nurse Donna Batchelor recorded on SystmOne[45]:

History: new admission transfer from police station.
appears active, high energy. speaks english.
vital obs [observations] *stable. has h/o depression, bi-polar disorder, diabetes type 2 diet controlled, pstd* [post-traumatic stress disorder] *and anxiety, depression*
on medication – Zopiclone [hypnotic medication for sleep] *and Tegretol* [trade name for carbamazepine, licensed for epilepsy but has a number of indications] . *pt stated that he has left him medicaton* [sic] *at home.*
No suicidal thoughts. No thoughts of deliberate self harm. denies torture.
appointment offered. slip given advised to attend nurse and doctor clinic to fill out SLP [sic] *assessments. pt als* [sic] *stated that he has an allergy to egg.*
ip [in-possession] *compact and disabilty* [sic] *form signed.*
consultation completed by Nana Yaa Dankwaa; HCA [healthcare assistant]
Second Reception Screening
Able to read
Illegible writing
Educated at mainstream school
Major: Not suitable for in-possession medication
Seen by health professional - nana yaa dankwaa
Allergic reaction - egg
Suitable for in-possession medication
Interpreter not needed
Smoker

[45] CJS002045 – D720 Patient Medical Records beginning at 25.3.17

Prison first reception health assessment completed

Has not stayed in a psychiatric hospital

No suicidal thoughts

No thoughts of deliberate self harm

O/E - **Sensitive/Irrelevant**

O/E -

Able to tell the time

Pulse rate 64 bpm

O/E - temperature 36.3 degC

Prisoner assessment for in-possession medication completed

Never

Not disabled

Fit for normal location, work and any cell occupancy

Diabetes mellitus - type 2 controlled diet.

Unknown

Observation of appearance of skin - appears intact

Has not received medication for mental health problems

Prisoner has not received treatment from a psychiatrist outside prison: no

Emotional state observations - appears calm

Prisoner has not tried to harm themselves (in prison)

Prisoner has not tried to harm themselves (outside prison)

Prisoner has a psychiatric nurse or care worker in the community : no

Depressive disorder (New Episode)

Heterosexual

Reasons for prisoner to see the doctor

h/o diabetes - type 2 diet controlled, bi-bolar, pstd [post-traumatic stress disorder] *and anxiety, depression.*

Fit to attend gym

Self medication assessment - low risk

Medical/psychiatric report not required: no

Adult male

Born in Grenada

Health information not received from outside source: no

Has no outstanding hospital/ Doctors appointments
Main spoken language Portuguese
Religion NOS
Speaks English well
142 / 98 mmHg
Medication In Possession Status: In possession - 28 days
Suitable for in-possession medication
Not suitable for in-possession medication

- In summary, this entry contains a '**first night**' reception screen along with a risk assessment for the detained **person's** suitability for having their medication in-possession. In this case, the in-possession status was set to '**28 days**' indicating that there were no significant concerns in regard to having medication in-possession.

5.200. On 25 March 2017 at 13:55 Dr Husein Oozeerally recorded on SystmOne:

History: explains that he is on tegretol, zopiclone an metformin [medication licensed for type 2 diabetes]. *He is on metformin PRN (he says his GP is aware of this). Plan: I have asked him to fill GP consent and then we can prescribe medication*

- In summary, it is important to note that Dr Oozeerally would need to seek confirmation from the community prescriber before being able to safely prescribe medication rather than relying solely upon the detained **person's** account of their medical and medication history.

5.201. On 25 March 2017 at 14:04 nurse Mariola Makucka recorded on SystmOne:

History: Request for GP notice
Examination: DR request GP medical records
Detainee signed consent and will be fax on Monday
GP details

Queensbridge Group Practice

24 Holly Street London E8 3 XP

DPA

DPA

5.202. On 27 March 2017 at 09:10 fax sent to Queensbridge Group practice:

- In summary, the faxed information included the signed consent form from the detained person which would normally be required by the receiving practice to process the request for the medical information.

5.203. On 01 April 2017 at 23:58 nurse Nombulelo Sihali recorded on SystmOne:

History: 22.00hrs went to see detainee whom was complaining that he did not have his medication since he arrived at the centre. Examination: Became vocal accusing health care of negligence explained to him that we are still waiting for his medical notes.
Diagnosis: Not happy that he is not on any medication was seen by m/o but awaiting for his records.
Plan: Advised him to come to healthcare in the morning, according to him his bm [blood glucose] *was 3 mmol and he thinks its because of not having his medication, explained to him that if he was on medication the blood sugar would be high by now.*

- In summary, the information requested from the Queensbridge Group Practice had not yet been received and this would have been the reason that the requested medication would not have been prescribed.
- In summary, the **nurse's** assessment of the detained **person's** blood glucose level demonstrated that it fell within the normal range at this time.

5.204. On 03 April 2017 at 00:35 nurse Nombulelo Sihali recorded on SystmOne:

History: 00.30hrs first responce [sic] *on wing, on arrival detainee was hyperventilating*
Examination: Breathing excesis [sic] *shown and later settled down*
Diagnosis: According to him he was having a conversation with his girl freind [sic] *and had an argument and started panicking*
Plan: Observations were satz [sic] *985* [98.5]*, pulse 85 and bm 4.4 mmol. Re assured advised him to avoid speaking to his girl freind* [sic] *and to speak to health care if he has any more attacks . Given a glass of water to drink which also help him.*

5.205. On 04 April 2017 at 13:56 the fax was received from Queensbridge Group Practice:

- In summary, the faxed information indicates that D720 was registered under an alias and was last seen on 07 December 2015 by Dr Hannah Fox. Dr Fox prescribed carbamazepine 200 mg, one tablet to be taken three times daily for four weeks.
- Following on from this consultation, there were a series of missed appointments for '**mental health**' (12 February 2016, 01 March 2016, 18 April 2016) and there was also a failed attempt to contact D720 by telephone on 20 March 2017.
- It should be noted that it took eight days for the Queensbridge Group Practice to provide their response to the healthcare team in Brook House.
- I found no evidence within the Queensbridge Group Practice record that D720 has been diagnosed with type 2 diabetes or had been prescribed metformin. I have not been provided with the full community GP record.

5.206. On 05 April 2017 at 14:03 nurse Donna Batchelor recorded on SystmOne:

History: came to pharmacy during medication time complaining he hasnr [sic] *had his medications in over 2 weeks.*
Examination: he became verbally abusive and said he was getting "fucked off" with being neglected due to not having his medications, I have explained that request for

medical notes has been done. he then said he was goinf [sic] *to smash the health centre up and to give him his card back.*
Plan: will chase with admin record status

5.207. On 11 April 2017 at 10:24 Dr Husein Oozeerally recorded on SystmOne:

History: Angry during consultation asking for tegretol which he last took 2 years ago (and he admits it). I have explained that he will need reassessment but he is repeated questioning this and wants to know when he will be seen. He says he has difficulty controlling his moods because he does not take his medication. He storms out of room, shouting loudly.
Plan: referred to Mental Health: to review diagnosis
Referral to [D720]

- In summary, this entry indicates that Dr Oozeerally had reviewed the information provided by the Queensbridge Group Practice and determined that D720 had not been taking this for some time and that a referral to the mental health team would be needed to confirm the underlying diagnosis and relevant indication for treatment.
- In my opinion, Dr **Oozeerally's** management was appropriate. I have reached this conclusion on the basis that it was otherwise reasonable not to prescribe medication for D720 without an appropriate indication for doing so. The plan to refer for further assessment with the mental health was also reasonable.

5.208. On 11 April 2017 Dr Husein Oozeerally completed a referral to the mental health team[46]:

His notes show that he has been on tegretol in 2015 and has been having poor compliance, The diagnosis of bipolar is seen on the notes but he displays symptoms of personality disorder with labile mood and displays of anger.

[46] CJS001947 – G4S Mental Health Referral Form D720 dated 11.4.17

- In summary, this document confirms Dr **Oozeerally's** action to make a referral to the mental health team.

5.209. On 13 April 2017 at 11:07 nurse Emily Parr recorded on SystmOne:

History: Seen in healthcare - requesting rule 35 due to abuse from father, Examination: multiple injury, burns, stab wounds in arms, from 08-11yrs in Grenada and UK then taken into care

5.210. On 18 April 2017 at 13:43 Dr Saeed Chaudhary recorded on SystmOne:

History: Would like rule 35
He mentions abuse took plce upto [sic] *the age of 11, occured* [sic] *in Granada and then started here. He mentions he was being burnt and beaten adn* [sic] *treated badly. He mentions came to UK in 1999. Was taken in to care due to neglect and abuse. He mentions had indefinite remain to leave and mentions was in prison and. He mentions his mother has been killed in Granada due to government wanting his father to be killed. He mentions his whole family is in the UK*

5.211. On 19 April 2017 a Rule 35 (3) report was completed[47] by Dr Oozeerally:

Section 4:
This patient mentions that physical and emotional abuse took place up to the age of 11. He mentions it occured [sic] *in Granada and when he moved here to the UK aged 8 it started here. He mentions he was being burnt and beaten and treated badly by his father.*
He mentions he came to the UK in 1999. He was taken into care due to neglect and abuse by his father. He mentions he had indefinite remain to leave and mentions he was in prison for offences as well. He mentions his mother has been killed in Granada due to the government wanting his father to be killed (due to political war) and ended up killing his mother instead. He mentions his whole immediate family is in the UK.

[47] CJS000845 – Rule 35 report relating to D720 - 19/04/2017

He mentions that the only connection he has in Granada is his father and that he is known by the locality there who he is and who his father is. As a result he mentions that the people after his father are also after him, He fears for his life if he was to be deported as he claims the people who want his father dead will intend to kill him.

Section 5:
He shows me a scar 3 x 3 cm on the left forearm and the upper arm. These are all wide and irregular suggesting not having stitches.
He shows me a scar on the left forearm and a small scar mark on the right forearm and the back of the right hand 1cm which he claims was from being burn by a lighter by his father.
Also a cut on the left back of the hand 1cm.
He shows me a small cut under the right eye 1cm
Also above the left eyebrow there is a small scar and also under the left lower eye lid where he mentions his father threw a small TV at him.
Also thee are a few marks on the arms faded scars.

Section 6:
This patients scars are consistent with his account.

- In summary, there is considerable detail recorded within sections 4 and 5 of this Rule 35 (3) report. Whilst Dr Oozeerally concludes in section 6 that the history and examination findings were consistent with one the account provided, he does not make any reference to his views on whether or not ongoing detention was having any impact at this time.

5.212. On 25 April 2017 at 09:58 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History:
Claims his parent were born in Jamaica, before they migrated to Grenada because of treats they received which was due to political differences. Said his mother was killed in his presence and he was living with his father who abused him. He had showed several marks on his hands to confirms this.
Came to the UK to live with his father when he was 8 years old.

Reports that suffers with Bipolar and was being treated for same up about 2 years ago. Claims he did not get to continue with his treatment or to have his mental health assessment completed because he had was to changed address after he was thrown out of his cousin house because he refused to sell drugs. Adding to this [D720] *said he was prescribed Tegretol because of his mood which he described as being very high (manic) and sometimes very low.*

Complain that he has been having flashback of the abuse he suffered from his father and he sometimes has thoughts of harming himself. Said he tried to kill himself twice when he was in prison because he was feeling hopeless and on one occasion he took and overdose.

Described some of his behaviour to be very erotic [sic] *without knowing that it was so until he was informed about this by others. Said he is worried that he might becoming unwell and would like his medication to be reinstated. Reports that sometimes he cannot control himself*

Mental State Examination:

Slightly restless and anxious during the session, his mood was also slightly elevated and he was speaking at a fast rate. Was not well kempt as his personal hygiene need to be improved, Did not appears to be distracted during the session. He was stuttering at times, was orientated to time date and place.

Went to see the doctor regarding [D720] *after the session. He would rather have* [D720] *seen by the Psychiatrist before he can prescribed the medication for* [D720] *as he had not taken same for the past 2 years. He has been placed on the psychiatrist list for the 27/04/17 slip has been sent.*

Plan: RMN support to continue, appointment has been given for the 03/05/17 at 10:00, slip given.

- In summary, this is the first assessment by the mental health team following Dr **Oozeerally's** referral to them on 11 April 2017. It should be highlighted that nurse McNaught-Dowd made a plan to both keep an ongoing review with the Registered Mental Health nurses as well as making an appointment for D720 to be seen by the psychiatrist on 27 April 2017.

5.213. On 26 April 2017 there is a Removal from association form:

- In summary, Form DCF1 is attached to the SystmOne record [Page 80].

5.214. On 27 April 2017 at 15:16 mental health nurse Karen Churcher recorded on SystmOne:

> *History: Dr Belda. Seen with RMN at the mental health office.*
> *Examination:* [D720] *background was assessed by RMN Dehlia. (Many thanks)*
> *He has explained that he experiences mood swings, hypomania-mania and depression. His hypomanic episodes can last for a few weeks and he tends to get into trouble. His deporssive* [sic] *episodes can last for a few months. He describes classic* [sic] *symptoms of hypomania (increased energy, reduced need for sleep, disinhibition* [sic]*, irritability, impulsivity and hyperactivity, pressure of speech) which are noticed by other people. When he is depressed he feels low in mood, lethargic with poor energy, poor motivation and poor concentration as well as suicidal thoughths* [sic].
> *He feels slightly elated now, but he puts it down at the fact that tomorrow he can get bail to the community.*
> [D720] *was diagnosed with Bipolar Diorder* [sic] *when he was in prison and he was successfully treated with Carbamazepine. (Although it caused him to have weight gain and poor coordination).* [Redacted].
> [D720] *denies having ever taken stimulant drugs and only admits to having taken cannabis.*
> *In addition to his Bipolar symtpoms* [sic] *he also suffers from PTSD* [post traumatic stress disorder] *symtpoms* [sic] *which originate from witnessing his mother's murder at the age of 8 and severe physical and emotional abuse form his father. He has many scars from his father's abuse. He was in care from the age of 11 which did not help matters.* [D720] *suffers from intrusive memories and imagery from him mother's death as well as nightmares and low startle reaction which is worse at night; this is the reason for him to at E Wing as he needs a single cell.*

[D720] *lives with his partner and their 2 year old girl. His partner is now 8 months pregnant.*
He has had other partners and his prevoius [sic] *partner had an abortion when she was 8 months pregnant which has been very traumatic for him.*
Information from GP notes
[D720] *has taken 2 overdoses of Carbamazepine prescribed by the GP (He has not made reference to this)*
Diagnosis: Bipolar Affcetive [sic] *Disorder; PTSD;*
Plan: 1- To initiate Aripiprazole 5mg mane for the 1st week to be increased to 10mg mane thereafter.
2- If he does not get bail I will review next week, and if he gets bail tomorrow he should be referred to his local CMHT in South Essex. I have asked him to consider Aripiprazole depot option should he benefit from the oral medication, but he is reluctant to accept it.
3- He will benefit from trauma therapy in the community; if he does not get bail he will benefit from RMn sessions.

- In summary, the psychiatrist confirmed diagnoses of bipolar affective disorder and post traumatic stress disorder and further makes a recommendation that aripiprazole 5 mg daily should be commenced with a further titration to 10 mg after one week.
- As a GP, it falls outside of my expertise to comment on the assessment and management undertaken by the psychiatrist.
- Aripiprazole is an atypical antipsychotic medication which has a license for treatment and maintenance in schizophrenia as well as the treatment and recurrence prevention of mania.
- The records provided by the Queensbridge Group Practice did provide information in the form of a discharge summary relating to an overdose of carbamazepine in November 2015.

5.215. On 27 April 2017 at 16:15 Dr Husein Oozeerally recorded a prescription on SystmOne:

- Aripiprazole 5mg tablets - 7 tablets - 1 tablet - admin times: 08:30 (Oral) (Future dated medication 28 Apr 2017)
- Aripiprazole 10mg tablets - 28 tablets - 1 tablet

- In summary, this entry demonstrates that Dr Oozeerally prescribed the aripiprazole 5 mg for D720 the same afternoon commencing the following morning for seven days with a further prescription for aripiprazole 10 mg, presumably as a follow-on prescription as per the **psychiatrist's** instructions.
- The prescriptions recorded by Dr Oozeerally were '**not**-in-**possession**' meaning that D720 would need to be administered the medication under supervision by the relevant member of the healthcare team each day.
- In my view, this demonstrates an appropriate response by the GP in considering the treatment plan recommended by the psychiatrist and subsequently to put in place an appropriate prescription of the required medication.

5.216. On 01 May 2017 at 11:15 nurse Melissa Morley recorded on SystmOne:

History: c/o missing medication doses.
States unable to wake up in the morning and has issues with the doses that are written up.
Unable to change doses due to evening dose.
Agreed with doctor that he can have a dose this afternoon as a one off

- In summary, this entry demonstrates that D720 was not fully compliant with the supervised medication because of difficulties in arriving for administration of his supervised medication.

5.217. On 02 May 2017 at 15:02 Dr Husein Oozeerally recorded a prescription on SystmOne:

- Aripiprazole 5mg tablets - 7 tablets - 1 tablet - admin times: 19:45 (Oral)

➢ In summary, this entry demonstrates that Dr Oozeerally promptly and reasonably adjusted **D720's** prescription to make it available in the evening rather than the morning.

5.218. On 03 May 2017 at 10:15 mental health nurse Karen Churcher recorded on SystmOne:

History: RMN
Examination: Did not attend his mental health appointment.
No reason given.
Plan: Further appointment offered for 6/5/17 at 16.00

5.219. On 05 May 2017 an unsigned completed Fit to Travel[48]:

➢ In summary, document includes **D720's** history of a '**psychiatric** condition' and the details of his current medication.

5.220. On 06 May 2017 at 16:05 mental health nurse Karen Churcher recorded on SystmOne:

History: RMN
Examination: Did not attend for his mental health appointment. No reason given.
This is the second appointment not attended. A further appointment will be made with a view to discharge if DNA.
Has an appointment on 11/5/17 with psychiatrist.
Plan: Psychiatrist appointment booked for 1115/17

5.221. On 07 May 2017 at 14:10 the following entry was recorded on SystmOne:

Did not attend for GP Appointments appointment with Brook House Doctor.
Did not attend

[48] CJS002457 – D720 - Fit to Travel form dated 5.5.17

Reminder/Alert: Did not attend for GP Appointments appointment with Brook House Doctor.
Please inform the patient that if they cannot attend an appointment in the future they should inform staff so that it can be cancelled ASAP. - Priority: Normal

5.222. On 11 May 2017 at 15:16 nurse James Newlands recorded on SystmOne:

History: Psychiatrist appointment
Examination: Did not attend this afternoon despite being called for on the wing on 2 occassions.

5.223. On 12 May 2017 at 03:12 nurse June Watts recorded on SystmOne:

Examination: 03.25Hr
[D720] *has been removed to CSU following episode earlier of throwing something and breaking a TV.*
Walked down to CSU and no assistance from officers.
He appears to be sleeping now.
According to officers on E wing/CSU when he arrived from the wing he asked an officer to charge his phone so he speak to his partner which was done.
[D720] *appears to be sleeping at time of visit and officers state he is calm and cooperative but does not like being disturbed when he is trying to sleep.*
Explained to him by officers that it is neccessary [sic] *at the moment until he goes back to the wing.*
R40 forms completed

- In summary, Form DCF1 is attached to the SystmOne record [Page 94].

5.224. On 18 May 2017 at 14:30 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History: Dr Belda. Seen with RMN.
Examination: [D720] *explained that he could not tolerate the Aripiprazole as when it was increased to 10mg he developed akathisia and stopped taking it. It had also caused him insomnia and anxiety.*

[D720] *was refused the bail which has increased his anxiety. He says that it was because the solicitors firm did not have a barrister to represent him.*
On the 12th of May he had an argument with his partner and feeling frustrated he threw an object impulsively. It hit the TV and the frame fell off. He was then put under Rule 40 and taken to CSU, but he is out of CSU now.
[D720] *is concerned with the plans to move him to Lincoln to another detention centre as it would jeopardise the relationship with his partner (who is pregnant) and their 2.5 years daughter; they would struggle to visit him.*
Diagnosis: Bipolar Disorder (Diagnosis made by the psychiatrist to used to see him in prison). PTSD.
Plan: I discussed with him the possibility of initiating Valproate, but I explained that he would have to undergo a blood test for liver function and he said that he has an overwhelming fear of needles. We the discussed about Olanzapine and he has agreed to this medication.
I recommend that he is prescribed 5mg of Olanzapine at night to be increased to 10mg at night after 1 week.
[D720] *has requested to receive talking therapy re his trauma. He meets the criteria for PTSD arising from witnessing his mother's murder when he was 8 years old as well as being physically and emotionally abused by his father for a long time.*

- In summary, **D720's** review with the psychiatrist concluded that changing to an alternative antipsychotic medication, olanzapine, should be trialled given the side effects he had experienced with the aripiprazole.

5.225. On 18 May 2017 at 16:31 Dr Saeed Chaudhary recorded a prescription on SystmOne:

- Olanzapine 5mg tablets - 14 tablets - 1 tablet - admin times: 19:45 (Oral)

- In summary, this entry confirms that Dr Chaudhary followed the treatment plan provided by the psychiatrist and commenced the olanzapine 5 mg as directed. The

SystmOne records also reflect that the prescription for aripiprazole was also stopped on this day.

5.226. On 21 May 2017 at 11:02 nurse James Newlands recorded on SystmOne:

History: RMN appointment
Examination: Did not attend with no reason given for this.
Plan: New appointment arranged for 28/05/2017 at 10:30, appointment slip sent to the wing.

5.227. On 25 May 2017 at 14:07 Dr Saeed Chaudhary recorded a prescription on SystmOne:

- Olanzapine 10mg tablets - 28 tablets - 1 tablet - admin times: 19:45 (Oral)

➢ In summary, this entry confirms that Dr Chaudhary followed the treatment plan provided by the psychiatrist and increased the dose of olanzapine to 10 mg as previously directed.

5.228. On 25 May 2017 at 16:13 mental health nurse Skeete Jitta recorded on SystmOne:

History: Dr Belda. seen at the Mental Health office.
Examination: He has been on Olanzapine 10mg nocte and reports that his mood is more stable and he is no longer worried about things that used to worry him. [D720] *is not having major side effects. He sleeps abut 5 to 6 hours but he says that it is better than it was. He feels lethargic for about 20 to 30 min in the mornings, but this lethargy dissappears* [sic] *afterwards. Appetite has been decreased paradoxically, but I have advised him to keep exercising as he has been doing in order to prevent metabolic syndrome.*
[D720] *feels more positive in general.*
Diagnosis: Bipolar Disorder (His symptoms are now in remission).
Plan: To continue on Olanzapine 10mg nocte.
I have advised him to book sessions with RMNs. (He missed appointments last week due to having been phyisically [sic] *ill with a virus)*

5.229. On 28 May 2017 at 10:21 nurse James Newlands recorded on SystmOne:

History: RMN appointment
Examination: Did not attend with no reason given.
Plan: New appointment has been arranged for 02/06/2017 at 15:00, appointment slip sent to the wing

5.230. On 02 June 2017 at 15:19 mental health nurse Karen Churcher recorded in SystmOne:

History: RMN
Examination: Came late to his mental health appointment.
Therefore had a brief session.
Thinks he maybe getting low in mood but does not present as if low.
has bail hearing on 6/6/17 and is positive.
Missing his daughter.
Wishes to continue with mental health input.
Plan: Appointment givne [sic] *for 9/6/17 at 1.30*

5.231. On 06 June 2017 at 23:29 mental health nurse Edward Omoraka recorded on SystmOne:

I was called to C wing 101 by an officer to access a detainee who had verbal altercation with an officer and reported that the officer used force to restrain him. On examination, his right upper arm appears redish, [sic] *no significant injury occured* [sic]. *He was able to move his hand all over his body when ask to do so.*
This incident happened during the day shift at about 16.55 according to the detainee.
F213 Form was completed.

- In summary, this entry is supported by a scanned copy of the F213 form attached to the SystmOne records [Pages 100 – 101].

5.232. On 06 June 2017 video footage[49] shows the nursing staff responding to a collapsed detainee on the floor:

- In summary, the footage demonstrates a nurse attending to a detained person surrounded by a number of custodial officers who initially appears unconscious but then rouses and stands to his feet and becomes aggressive to the staff surrounding him.

5.233. On 09 June 2017 at 14:05 mental health nurse Karen Churcher recorded on SystmOne:

History: RMN
Examination: Did not attend his mental health appointment. No reason given.
Plan: Further appointment offered for 15/6/17 at 10.30

5.234. On 13 June 2017 at 13:34 Dr Husein Oozeerally recorded a repeat prescription on SystmOne:

- (R) Olanzapine 10mg tablets - 28 tablets - 1 tablet - admin times: 19:45 (Oral)

- In summary, this entry confirms that Dr Oozeerally followed the treatment plan provided by the psychiatrist and continued the dose of olanzapine at 10 mg and put this medication on repeat prescription.

5.235. On 15 June 2017 at 10:49 nurse Dahlia McNaught-Dowd recorded on SystmOne:

History: RMN
Examination: Did not attend his mental health appointment. This is the second appointment in a row that he has not attended.

[49] TRN0000089 pg. 2-3

A follow up appointment to be offered with a view to discharge if DNA
Plan: Follow up appointment offered for 16/6/17 at 10.30

5.236. On 16 June 2017 at 10:14 nurse James Newlands recorded on SystmOne:

History: RMN appointment
Examination: Did not attend with no reason given. This is the 3rd appointment missed and has now been discharged
from the mental heal team caseload.
Plan: To re-refer should he want to engage with us in the future.

5.237. On 28 June 2017 at 13:19 nurse James Newlands recorded on SystmOne:

History: RMN appointment
Examination: Did not attend with no reason given. This is the 3rd appointment missed and has now been discharged
from the mental health caseload.
Plan: To re-refer himself should he want to engage with us.

5.238. On 08 July 2017 Edward Omoraka completed a Fit to Travel form[50]:

- In summary, document includes **D720's** history of a '**psychiatric condition**' and the details of his current medication, including *'**non**-compliance with his **medication**'*.

5.239. The last entry in the SystmOne records is on 13 July 2017.

5.240. In summary, the records provided indicate that following his detention in Brook House Immigration Removal Centre, the healthcare staff reasonably sought information from the community general practice and where this was insufficient to confirm **D720's** reported past

[50] CJS002148 – D720 - G4S Health Fit to travel form dated 8.7.17

diagnosis and treatment, arranged for him to be seen and assessed by the mental health team. D720 was ultimately assessed by a psychiatrist and treatment with medication was commenced. D720 was non-compliant with the first medication offered to him because of side effects and so further treatment with an alternative was provided for him. I have not been able to establish how compliant D720 was with his medication although records suggest that he was not. It is further noted that despite having offered a number of appointments for him, D720 repeatedly '**did** not **attend**' for these. In my view the care provided to D720 in regard to his apparent mental health disorder was adequate.

D1538

5.241. In summary, this case relates to a DPA year-old gentleman of Moroccan origin who was received into Brook House Immigration Removal Centre on 01 June 2017. He was transferred to IRC The Verne on 14 June 2017 and then returned back to Brook House on 27 June 2017. D1538 was then transferred to Heathrow Immigration Removal Centre on 15 July 2017.

5.242. On 01 June 2017 at 23:17 staff nurse Lyn **O'Doherty** recorded on SystmOne[51]:

History: Arrived from Maidstone Police station. Not on any medication. Denies thoughts of self harm/suicide. Says he ran away from his family aged 8. Came to UK 4 yrs ago via land & lorry. Moved around country staying with friends. Showed me several scars from fights & accidents. Concerned about scar on forehead as believes it contributes to his headaches sometimes. Wishes to see doctor -slip given to attend new arrival clinic. Did not attend school and unable to read or write Arabic but can read and write a little English. Able to communicate fairly well in English -compacts signed
Fit to attend gym
Main spoken language Arabic
General practitioner - none
Sexual orientation not given - patient refused
Prisoner has been in prison before - Was in Brook House 2015
Health information not received from outside source: no
Has no outstanding hospital/ Doctors appointments
Born in Morocco
Sensitive/Irrelevant
Speaks English well - has been in UK 4 yrs
Adult male

[51] CJS003639 – Medical Records - 01/01/2012 to 20/08/2017 - D1538

At risk state 1 - 1. patient has self-administered their prescribed medication in the community or another

prison?: No

2. The patient has understood and signed the IP medication compact?: Yes

3. Has patient any learning disabilities, problems with reading labels or language difficulties?: N/A

4. There is known history of medication related incidents e.g. trading, bullying, overdosing, non compliance, in the last 12 months recorded on the clinical IT system: No

5. The patients has an open ACCT document or had one closed within the past four weeks?: No

6.Is the patient confused or disorientated?: No

7. Has the patient had a recent change in prison status (e.g. recently sentenced) or a recent life event?: No

8. Is the patient under care of In reach or in the process of being referred?: No

Seen by health professional - LODoherty

Interpreter not needed

Cigarette consumption 10 cigarettes/day

Suitable for in-possession medication

No known allergies

Medical/psychiatric report not required: no

Minor: Suitable for in-possession medication

Prisoner assessment for in-possession medication completed

Self medication assessment - moderate risk

Unknown

Pulse rate 64 bpm

Smoker

Prisoners alcohol intake week before custody 0 Units /Week

Prison first reception health assessment completed

O/E - height Sensitive/Irrelevant

Unable to write - arabic none but a little English

Educated at mainstream school - never been to school

Second Reception Screening

O/E - **Sensitive/Irrelevant**

Able to tell the time

Able to read - arabic -none but reads some English

No thoughts of deliberate self harm

Fit for normal location, work and any cell occupancy

Impressions of the prisoners behaviour and mental state - co-operative

Prisoner has not tried to harm themselves (in prison)

Observation of appearance of skin - no issues

Never - denies

Not disabled

Prisoner has not tried to harm themselves (outside prison)

Emotional state observations - talkative

Has not stayed in a psychiatric hospital

No suicidal thoughts

Prisoner has a psychiatric nurse or care worker in the community : no

Has not received medication for mental health problems

Prisoner has not received treatment from a psychiatrist outside prison: no

136 / 80 mmHg

Medication In Possession Status: In possession - 7 days

Suitable for in -possession medication

- In summary, this entry demonstrates that a reception screening was undertaken.

5.243. On 02 June 2017 at 15:56 Dr Saeed Chaudhary recorded on SystmOne:

History: NEW ARRIVALS

Mentions no medical diagnosis.

No medications.

To discuss about other complaints in a seperate appointment.

Has had medical problem for 4 years and asked to book routine appointment

5.244. On 03 June 2017 at 15:08 mental health nurse Edward Omoraka recorded on SystmOne:

Detainee had an altercation with an officer, he was accessed physically, no injuries was sustained or reported by
detainee. F213 form and Rule 42 form was completed [Report attached at page 34].

5.245. On 03 June 2017 Care and Separation DCF 1[52] DC Rule 40 was completed.

5.246. On 03 June 2017 DC Rule 41 DCF Form 2[53] was completed.

- In summary, this form includes the statement from DCO Edmund Fiddy and includes a copy of the F213 report

5.247. On 03 June 2017 Incident Report[54] was completed.

- In summary, this form includes the statements from DCO Edmund Fiddy and DCO Luke Instone-Brewer

5.248. On 03 June 2017 IS.91RA Part C: Supplementary Information form was completed.

Detainee [D1538] *has been placed onto rule 40 after invading an officers personal space and then trying to grab officer aronnd* [sic] *the neck as the officer pushed him away.*

5.249. On 05 June 2017 at 11:31 staff nurse Carol Reed-Bishop recorded on SystmOne:

History: Seen by nurse
Examination: says he was stabbed in the back. He also says he has metal in his skull. Long time ago says he has
never seen the GP before about. Wants medication he says it has now started to hurt. Requests medication. Doesnt

[52] HOM002624 – Care and Separation - DCF 1 - DC Rule 40 for D1538
[53] CJS002901 – Use of Force form for D1538 on 03/06/2017
[54] HOM002629 – Incident Report Part One for D1538 - 388/17 - 3 June 2017

want to have paracetamol. I can see that a GP appointment has been already booked. He said he had lost his
appointment slip. I have given him a new one

5.250. On 06 June 2017 at 15:45 Armanath Persaud recorded on SystmOne:

History: Detainee was involved in an altercation with other detainees in the ART ROOM.
Seen by nurse after the incident on E.Wing.
Superficial scratches on both sides of his neck and on under the neck Over the right eye slight swollen area ..
F213 completed after the incident [F213 attached a page 35 of the record]

5.251. On 06 June 2017 at 18:50 staff Christopher Paynter recorded on SystmOne:

History: Alleged asult by other detainee-well being check
Examination: Seen on A wing - resting in cell - Right eye Injury uncertain if accidental or non-accidental - upper eyelid and rt temple swollen bruising evident - Perl - declined further obs -
no nausea - declined diet and fluids / medication as Rhamadam - discomfort but not painful limbs shoulder back of neck
Plan: further observations if symtoms persit - possible meds later

5.252. On 09 June 2017 at 14:40 Dr Saeed Chaudhary recorded on SystmOne:

History: Pt has multiple issues including headache and back ache adn other issues.
Asked patient what is important adn he woul dlike to start discussing about his headache.
He mentiosn he has had headache for the last 10 years, since being sruck in the head with a metal pole in and
attack.
OE mentions sharp feeling on palpation of the scalp.
Arrange x ray
Also wax in both ears, given oil to help.

5.253. On 14 June 2017 Fit to Travel form[55] was completed by Edward Omoraka.

5.254. On 14 June 2017 D1538 was transferred to IRC The Verne.

5.255. On 27 June 2017 D1538 returned to Brook House.

5.256. On 15 July 2017 D1538 was transferred to Heathrow Immigration Removal Centre.

5.257. On 24 July 2017 at 10:20 Dr Irfan Sayed at Harmondsworth Immigration Removal Centre completed a Rule 35 (3)[56] report:

> Section 4
> *He was attacked in 2007-2009 on many occasions in* DPA *Morroco. He was attacked by many people including his own family* [redacted]. *He was cut with knives and beaten with hammers also.*
> *He never went to a main hospital but self-referred to local clinics for treatment.*
> *He did not go to the police.*
> *He decided to flee Morroco in 2011-12 — in fear of his life.*
> Section 5
> *Incision scars on forearms and lower back*
> *- Laceration scars on top of head and forehead*
> Section 6
> *On examination he has scars which may be due to the history given*

5.258. On 25 July 2017 Home Office letter IS.335[57] to D1538

> *Dear* [D1538]
> *I am writing to you to acknowledge receipt of a report dated 24/07/2017 provided by the medical practitioner at Harmondsworth IRC Removal Centre notifying us of a special illness or condition. Information contained within the report has been considered carefully and the decision to detain you has been reviewed.*
> …
> *Immigration factors*

[55] CJS003308 – G4S Fit to travel form re: D1538, dated 14 June 2017
[56] CJS003632 – Rule 35 Report - 24/07/2017 - D1538
[57] HOM0322007 – Letter to D1538 from Home Office acknowledging receipt of a medical report

02/03/2014 — You were encountered in the UK as an illegal entrant and served with an IS.151A. You were released and placed on reporting restrictions

18/03/2014 — You claimed asylum in the UK. You were a EURODAC hit in Denmark. You were detained, served with an IS.91 R and referred to TCU

22/03/2014 — Formal Request made to Denmark under article 18.1(b) of the Dublin III regulation

22/04/2014 — Denmark accepted responsibility

23/04/2014 — Asylum refused and certified under Third Country grounds

06/06/2014 — Removed back to Denmark.

30/10/2014 — You arrived back in the United Kingdom clandestinely for a second time in the back of a lorry from Zebrugge Belgium. You did not claim asylum.

05/11/2014 — Case referred to Third Country Unit

18/11/2014 — Formal request made to the Danish authorities to accept responsibility.

11/12/2014 —You had a bail hearing — Bail granted with reporting restrictions.

02/01/2015 — Denmark accepted responsibility.

17/06/2015 — You were circulated as an absconder as you did not conform to bail conditions.

25/03/2016 — You were encountered after being arrested by the police. You were detained and served with an IS.91R

28/04/2016 — You were released and placed on reporting restrictions

14/03/2017 — You were encountered during an Enforcement Visit by Kent & Sussex ICE at [redact]. *You were cautioned, questioned and served with a RED.0001, RED.0003 and an IS.91R. You were released on reporting due to the allocation timescales of your asylum claim.*

02/06/2017 — You were detained at Maidstone Police Station and served with an IS.91R

08/06/2017 — You claimed asylum.

29/06/2017 — You were interviewed by Moroccan officials.

11/07/2017 — Detained Asylum Casework (DAC) accepted case.

17/07/2017 — Screening interview completed

18/07/2017 — DAC induction interview completed.

24/07/2017 — Asylum interview booked for 28/07/2017.

24/07/2017 Rule 35 received.

Balancing risk factors against immigration control factors

Your immigration history clearly shows that you cannot be relied upon to comply with any immigration conditions. You are an illegal entrant (twice) who has absconded. You made a late opportunistic claim for asylum after you had been detained. You have been disruptive and failed to comply with Immigration Rules. You therefore present as a substantive risk for absconding. It is noted that your substantive asylum interview has been scheduled to take place on 28/07/2017. This will be followed by the decision on your claim. Should your claim be certified, the decision will not accrue any statutory in-country Right of Appeal and given that you have no other legal basis to remain, your removal could be effected shortly thereafter. Should you be refused asylum and afforded in-country Right of Appeal, you would fall under the DIA expedited timescales and therefore your case would likely conclude in around 10 - 14 weeks. Should you be granted asylum at any stage you would of course be released. You have no close ties in the UK to ensure your compliance with any conditions of release. Given the clear evidence of non compliance with the immigration rules, it is considered that you are highly unlikely to be removable unless detained because it is considered that you cannot be relied upon to comply with any reporting conditions, especially those relating to your removal. Whilst it is noted that you have stated that you have encountered physical torture, Healthcare have not raised any concerns at this time that you may be unfit for detention. You are removable on an Emergency Travel Document and removal can be expected between 6 and 8 weeks if your application for asylum is unsuccessful.

Conclusion

When balancing the indicators of vulnerability against the negative immigration factors highlighted above and the imminence of your removal, it is considered that the negative factors outweigh the risks in your particular circumstances. Therefore a decision has been made to maintain your detention. A copy of this letter has been forwarded to your legal representative, where you have one.

5.259. In summary, this case provides an overview of a young detained person who has been in and out of the detention system for a significant period of time. The records also show

that he could be quite volatile and was involved in violence with other detained persons and custodial staff.

5.260. The record-keeping from healthcare and detention centre perspectives appears to be responsive and comprehensive. It is of note that despite the relatively brief periods of detention there were a number of incidents.

D1914

5.261. In summary, this case relates to a DPA year-old gentleman of Romanian origin who was received into Brook House Immigration Removal Centre on 29 March 2017.

5.262. On Wednesday 29 March 2017 at 23:21 healthcare assistant Katherine Wade recorded a reception screening questionnaire in SystmOne[58]:

> *History: new admsision* [sic] *from high wycombe* [sic]
> *CABG* [Coronary Artery Bypass Graft] *in november 2016, 3 X MI* [Myocardial Infarction] *before that*
> *has another operation date 7th august 2017 for another CABG*
> *past history of self harm, does not wish to self harm anymore.*
> *became angry and agigtated* [sic] *about immigration on admission* [sic], *abusive shouting and swearing at me and RGN Grace.*
> *not for IP* [in possession] *meds as history of self harm.*
> *Doctors appt made for tomorrow.*
> *Health information not received from outside source: no*
> *Prisoner has outstanding hospital or doctors appointment*
> *had appt at high wycombe* [sic] *hospital today but did not go*
> *7th august 2017 for another heart operation.*
> *Born in Romania*
> *Main spoken language Romanian*
> *Speaks English well*
> *Ischaemic heart disease*
> *Never*
> *Not disabled*
> *Observation of appearance of skin - healthy hydrated*
> *Unknown*

[58] CJS000990 – Detainee D1914 Patient Record, dated from 29/3/2017 to 27/08/2017

Health related observations about the prisoners physical appearance - no concerns
Major: Not suitable for in-possession medication
angry/agigtated [sic] *on admission*
history of self harm
Seen by health professional - k.wade
At risk state 1 - 1. patient has self-administered their prescribed medication in the community or another prison?: Yes
2. The patient has understood and signed the IP medication compact?: No
3. Has patient any learning disabilities, problems with reading labels or language difficulties?: No
4. There is known history of medication related incidents e.g. trading, bullying, overdosing, non compliance, in the last 12 months recorded on the clinical IT system: N/A
5. The patients has an open ACCT document or had one closed within the past four weeks?: N/A
6.Is the patient confused or disorientated?: N/A
7. Has the patient had a recent change in prison status (e.g. recently sentenced) or a recent life event?: N/A
8. Is the patient under care of In reach or in the process of being referred?: N/A
No known allergies
Interpreter not needed
Self medication assessment - high risk
Reasons for prisoner to see the doctor - CABG novmeber [sic] *2016*
Fit to attend gym
Sexual orientation not given - patient refused
Medical/psychiatric report required
Adult male
Fit for normal location, work and any cell occupancy
Pulse rate 69 bpm
O/E - height **Sensitive/Irrelevant**
Prison first reception health assessment completed
O/E - weight **Sensitive/Irrelevant**
Educated at mainstream school

Second Reception Screening
Able to write
Able to tell the time
Able to read
Prisoner has a psychiatric nurse or care worker in the community : no
Has not received medication for mental health problems
Prisoner has tried to harm themselves (outside prison) - has previous self harmed years ago, does not wish to do it again.
Impressions of the prisoners behaviour and mental state - alert orientated calm,
Prisoner has not tried to harm themselves (in prison)
Prisoner has not received treatment from a psychiatrist outside prison: no
No thoughts of deliberate self harm
Smoker
No suicidal thoughts
Emotional state observations - no concerns
Has not stayed in a psychiatric hospital
140 / 89 mmHg
Medication In Possession Status: Not in possession
Not suitable for in-possession medication - angry/agigtated [sic] *on admission history of self harm*

- In summary, this entry demonstrates that a reception screening was undertaken.
- This entry also included a series of questions to determine **D1914's** suitability for in-possession medication and it was concluded that he was not suitable for in-possession medication. From the available records, it appears that D1914 refused to sign the medication in-possession '**compact**' and such it would be reasonable to preclude him from having his medication in-possession. It is usual practice to request that detained persons sign a compact to indicate their understanding and commitment to using and looking after medication that has provided to them appropriately.

- It is noted that D1914 was agitated during this reception screening and it may have been the case that the full assessment, including the signing of the medication compact could not be completed because of his level of agitation.

5.263. On Wednesday 29 March 2017 at 23:30 healthcare assistant Katherine Wade recorded in SystmOne[59]:

History: came in with
Atorvastain [sic]
Aspirin 75mg
Bisoprolol
Clopidogrel 75mg
Lanzoprazole [sic] *30mg*
Ibroprofen [sic] *gel -given to him IP*
everything else cannot be given

5.264. On 30 March 2017 at 15:53 Dr Saeed Chaudhary recorded in SystmOne:

History: patient reviewed, all meds gven [sic] *to him in possession, pt* [patient] *advised ot* [sic] *come back in 2 days. Medicines checked and as listed prev atorvastatin 40mg and bisoprolol 10mg. Pt to come back in 2 days for med review.*

5.265. On 01 April 2017 at 13:57 Dr Saeed Chaudhary recorded in SystmOne:

History: Pt stormed in the room demanding to discuss about his medical problems, I have asked patient to speak to the nurses so they can filter the issue. Pt getting aggressive, raising his voice, threatening me saying 'I have a good Lawyer' and I will make a complaint. Pt doesnt [sic] *seem to want to engage in the healthcare process here. I asked patient ot* [sic] *leave adn* [sic] *speak to the nurse several times. he stood up and acted aggressively, I felt threatened. I called an officer who came a few mnutes* [sic] *later but patient had already left. he was heard swearing in the waiting room before going. pt had an appointment this mornign* [sic] *where he didnt turn up. I kindly did his medications for him but pt not keen to engage in the helthcare* [sic] *process.*

[59] CJS000990 – Detainee D1914 Patient Record, dated from 29/3/2017 to 27/08/2017

5.266. On 11 April 2017 at 14:55 H Bennett recorded within the ACDT document[60]:

I saw [D1914] *in visits today for an immigration interview to serve deportation paperwork. He became extremely upset and agitated which quickly escalated to anger where he was shouting and swearing at me. He said he would be dead within the hour due to his heart condition. I checked he* ***didn't*** *feel suicidal and he confirmed he* ***didn't*** *but said his heart was not good and he was due to have further heart surgery in August. He left the interview shouting and upset so I called his wing to ask an officer to check on him.*

5.267. On 11 April 2017 IS.91RA Part C: Supplementary Information to IS.91 RA Part A completed by Philip Page[61]:

Detainee [D1914] *has been placed on an ACDT after suggesting he would die if returned to Romania.*

5.268. On 12 April 2017 at 09:40 D Robinson recorded within the ACDT document:

This morning we have spoken to Mr [D1914] *in the Talking Therapy Room, I requested that DCO Kavangh was present as she conducted the Assessment, Mr* [D1914] *initially appeared in good spirits and told us that he has no thoughts or intentions to hurt himself and that he made a comment yesterday that "he will die in detention". Mr* [D1914] *explained that he has had several heart operations and wanted to speak to the Doctor about his medication. Mr* [D1914] *stated that his comment was made in jest and that he doesn't plan to harm himself. We asked Mr* [D1914] *about the scars on his arms, Mr* [D1914] *admitted to us now and to DCO Kavanagh prior that he doesn't exactly remember how he made the scars but it was about 15 - 20 years ago and in his words he has "grown up" Mr* [D1914] *spoke about his family and how he would hurt himself because of them and they are his support network and regually* [sic] *visit him in detention, Mr* [D1914] *also informed us that he has his own construction business. It was agreed that after the review Mr* [D1914] *was going to see the Nurse to get another Doctors appointment booked, DCO Kavanagh gave Mr* [D1914] *a phone call*

[60] CJS001043 – HO Care of At Risk Detainees ACDT Plan re D1914 dated 11.4.17
[61] CJS001033 – IS91RA Part C

to his GP to request his medical notes during the Assessment. (On Careplan as now complete). It was agreed that Mr [D1914] *ACDT could be closed due to no feelings of self harm or suicide and that he has a Solicitor working on his case with a close family support network.*

5.269. On 12 April 2017 Dr Husein Oozeerally documented in a letter addressed to the Home Office[62]:

The above detainee remains fit o fly and fit for detention.

5.270. On 12 April 2017 at 09:39 mental health nurse Karen Churcher recorded in SystmOne[63]:

History: ACDT review.
Examination: Seen in talking therapies with DCM Dan.
States he has no intention of harming himself.
Feels his comment was taken out of context.
He meant that if he was sent back to Romania he would be died on the inside.
Presents as polite, cheerful and engaging.
Plan: ACDT closed.

5.271. On 15 May 2017 at 10:49 staff nurse Melissa Morley recorded on SystmOne:

History: ECG taken. For dr to review.
C/o tightness in chest and difficulty in breathing.
Shows sternotomy scar and states that this is causing him pain, claims discharge? sweat from scar site.
Has stated that if he is not taken seriously, then he will stop taking his medications, foods and fluid.
Plan: For dr to review this afternoon.
Pulse rate 54 bpm
141 / 87 mmHg

[62] CJS001144 – G4S Health Letter from Dr Husein Oozeerally to Home Office confirming D1914 is fit to fly, dated 12/4/17
[63] CJS000990 – Detainee D1914 Patient Record, dated from 29/3/2017 to 27/08/2017

5.272. On 15 May 2017 at 15:44 Dr Husein Oozeerally recorded on SystmOne:

History: says ongoing intermiitent [sic] *sternal and subcostal pain at scar sites.*
He is not SOB currently but says that gets a mechanical chest tightness on occasional.
He talks about infection and concerns
Examination: 97% RR12
chest clear
HS normal
Plan: CXR and BT for tomorrow.
note ECG normal
O/E - pulse rhythm regular
Pulse rate 61 bpm
Codeine 30mg tablets - 41 tablets - 1-2 tablet - admin times: 08:30, 13:30, 19:45 (Oral)
(Future dated medication 18 May 2017)
140 / 98 mmHg

5.273. On 16 May 2017 at 09:10 Miss Havva Daines recorded on SystmOne:

History: C/o chest pain from left hand to shoulder.
ECG sinus rhythm.
SpO2: 98% on RA.
To come to HC [healthcare] *for observation recheck at 13:30.*
Aware to come back to HC if any concern.
O/E - pulse rhythm regular
Pulse rate 64 bpm
173 / 105 mmHg

5.274. On 16 May 2017 at 21:02 nurse June Watts recorded on SystmOne:

History: received a phonecall from Dr. Ikoton at crawley hospital stating that his blood result was abnormal and he has Ddimer [D-dimer] *of 600 and to go to hospital ASAP*
Diagnosis: called redhill oncall to check results as the doctor would not give us a contact number
Plan: Ringing a GP Ambulance to take [D1914] *to east surrey hospital*

reference number for ambulance service ref: 26593525
Detainee brought to healthcare to discuss the blood results and that he needs to go to hospital asap for treatment as his blood test was not normal.
Initially he did not want to go tonight but I explained to him the importance of early treatment. and why.
His wife [redacted] spoken to and explained to his wife the importance of early treatment and that he will be coming
back to Brook House after treatment.
After speaking to his wifer he agreed to go to hospital tonight
Observations
Detainee appears quite pale and breathless on exertion
173 / 101 mmHg
P 69
Sats 99% on R
36.6

5.275. On 16 May 2017 at 23:27 nurse June Watts recorded on SystmOne:

Examination: 23.27Hr
Detainee now fed up of waiting for ambulance and wanting to smoke if he can not smoke he will not go to hospital
until tomorrow
Oscar Phil contacted and only solution is for [D1914] *to go back to his room where he can have a cigarette (1) and*
when ambulance arrives to come back .
[D1914] *also states he feels better now but he has not been active while in healthcare.*

5.276. On 17 May 2017 a Security Information Report[64] was completed by David Booth, Scott Milliken and Lee Blake:

On 17th May 2017 at approximately 1600 hours I was on a hospital escort with DCOs D. Booth and L. Blake waiting in the Acute Medical Unit waiting room at East Surrey Hospital with detainee [D1914]. *Detainee* [D1914] *abruptly became abusive towards*

[64] CJS004720 – D1914 – Security Information Report 17/05/2017

DCO D. Booth after it was explained to [D1914] *that he is not allowed to go outside for a cigarette as we are waiting for the doctor to see him.* [D1914] *shouted a number of profanities at DCO D. Booth including "Fuck Off" and "You bitch, fuck off". Attempts were made to calm* [D1914] *down but these were met with further abuse. It was decided to terminate the escort and return to Brook House due to his behaviour. When leaving Acute Medical Unit to return to the company car* [D1914] *made a threat towards DCO L. Blake, saying he will show him what he can do.* [D1914] *was told that this is not acceptable behaviour. This concludes my report.* [Scott Milliken]

5.277. On 19 May 2017 James McCabe completed an Airline Risk Assessment[65]:

The passenger has serious criminal conviction in the risk 1 category and does not wish to return so escorts are being sued to mitigate risk of disruption.

5.278. On 24 May 2017 at 20:15 nurse Nombulelo Sihali recorded in SystmOne:

History: 20.00hrs detainee came in to collect his medication , when given he asked where his aspirin was Examination: I noticed that he was given on the 01/05/17 x28 tablets.
Diagnosis: He ocnfessed [sic] *that he is taking x2 aspirin as times when explained he became verbally abusive and swearing called the officers and he calm down*
Plan: Now he needs more aspirin would like m/o to explain to him the dangers of over dosing himself.

5.279. On 25 May 2017 at 09:46 nurse Donna Batchelor recorded on Systmone:

History: medication request
Examination: states ran out asprin was prescribed asprin 15/5 but only has a few left- states been taken more than prescribed has small bruising noted to abdomen, was stating he took more because his blood pressure was high. he became verbally agressive when i explained asprin was not for blood pressure and this is the most likely cause for his bruising and he must not take more than prescribed. in light of his non

[65] HOM006304 – D1914 Airline Risk Assessment dated 19 May 2017

compliance i feel he is unsafe to be allowed to continue having medications In Possession.
Plan: doctor to review admin task. currently red risk ip
asked officer to issue warning to detainee request to C wing to remove medications from detainees possession and return them to healthcare

5.280. On 25 May 2017 at 14:42 Dr Saeed Chaudhary recorded on SystmOne:

History: Pt reviewed, mention shas still 10 tablets of aspirin left, mentions was taking two at times, has bruise on abdo, small bruise mentions was on the abdo from last week.
Advised to come to take meds tomorrow.
Advised c wing to give pt tablets back. Will monitor medications.

5.281. On 27 May 2017 Dr Husein Oozeerally documented in a letter addressed to the Home Office[66]:

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 and R) in order to facilitate the removal.

5.282. On 27 May 2017 video footage[67] shows Mr Callum Tulley discussing the case of D1914 with another custodial officer:

- Mr Tulley and another Custodial officer were seen viewing records pertaining to D1914 and discussing history of offences visible on the system. At 1:00, the conversation turns to his past medical history, previous heart attack and that he is apparently awaiting triple bypass surgery. There is a further discussion in regard to his presenting with chest pain when flights are discussed. Towards the end of the

[66] CJS001160 – Fitness to fly and detention letter re D1914 from Dr Husein Oozeerally to G4S and Home Office, dated 27/5/17
[67] TRN0000087, pg. 19

clip they appear to be discussing the possibility of a control and restraint and the officer is heard to say *"If he dies, he dies"* and appears to be smiling at the time. Mr Tulley responds *"I hope not"*.

5.283. On 27 May 2017 video footage shows the movement of D1914 from his room to E Wing[68]:

- In summary, the video footage shows Mr Tulley holding a shield outside a room. At 06:20, what appear to be two other officers wearing helmets enter room and quickly call for health care to check over detained person. The detained person is seen laying on his left side on the bed. At 06:40 the detained person sits up - his face can be seen; he does not appear to be sweating or distressed. At 06:55, healthcare appear to enter from right and another officer appears, in uniform rather than protective equipment. Healthcare appear to be tending to detained person, presumably blood pressure (velcro of cuff heard at 08:05). At 08:23 Officer 'Nathan' appears to C's left holding video recording device and pointed at the detained person. A conversation then ensues with the detained person but it is very muffled. At 10:20 healthcare requests oxygen saturation machine. He appears to be talking to another nurse who is off camera and this person apparently says the *"blood pressure is good"*. Healthcare staff mentions a number "[inaudible]... *94", "That's fine"*. At 11:10 an officer is heard to speak and say *"So, Mr* [D1914]*, you are going to go to E wing"*. He is asked whether he will walk voluntarily and is advised that if he does not, he will be assisted. He declines to stand and the two officers in protective equipment commence to lift him up. At 11:43 the detained person says,

[68] BBC000092 – KENCOV1025 – V2017052700020 – 27 May 2017 – 05:27-23:42, TRN0000013; TRN0000014

"I'm not a criminal, why you do this?". At 12:30, Mr [D1914] is advised that if he does not comply he will have handcuffs applied and he will be carried, which will hurt. At 13:19, Mr [D1914] fails to stand after some negotiation in regard to phone calls and cigarettes. AT 13:53, the order is given to puts his hands behind his back. At 14:00, Mr [D1914] is heard yelling. At 15:00 he says, *"I'm finished, OK I'm good"*, and is heard breathing heavily. At 16:36, Mr [D1914] is moved from the floor to the bed. At 17:10, appears to be standing and walking but is assisted on either side by two officers. At 17:25 he looks at Mr Tulley and states *"I am not feeling good"*. He does not appear distressed as he leaves his room. He is not sweating or grimacing. I can see his midline sternotomy scar. He is then seen walking at a modest pace down the length of the wing without hinderance. At 20:20, he arrives in another room. Cuffs are removed at 22:01. Towards the end of the clip, Mr Tulley is talking again to an officer he previously spoken to in the car park. Very difficult to understand what was said. The Officer appeared to have been one of those involved in the control and restraint manoeuvre.

5.284. On 27 May 2017 at 21:30 Steve Leighton completed section 2 of the Report of Injury to Detainee form F213[69]:

No injury sustained. Planned intervention on [D1914] *due to facilitate his escorted removal directions on 28/5/17. Hand cuffs were applied to relocate him onto Eden wing. Healthcare were present at all times and carried out physical observations after intervention.*

5.285. On 27 May 2017 at 21:30 Use of Force DCF2[70] form was completed.

[69] CJS004327 – G4S Report of Injury to Detainee for D1914, dated 27/5/17
[70] CJS004348 – Use of Force Report on D1914, dated 27/5/17

- In summary, this is a 29-page document containing a list of staff present, the reasons for the Use of Force and detailed statements from a number of the Detainee Custody Managers and Officers involved (Dave Webb, Steve Dix, Yan Paschali, Jonathan Edon, Callum Tulley).

5.286. On 27 May 2017 Incident Report[71] form was completed.

- In summary, this is an 8-page document containing an incident statement from Detainee Custody Manager Nathan Ring, Detainee Custody Manager Steve Dix, Detainee Custody Officer Jonathan Edon, Detainee Custody Officer Daniel Lake.

5.287. On 27 May 2017 at 21:45 Care and Separation DCF1[72] form was completed:

Mr [D1914] *was placed onto rule 40 and constant supervision for refusing to locate to Eden Wing.* [D1914] *has medical issues so placed on constant supervision.* [D1914] *was placed on rule 40 to maintain good order and discipline of the centre. Home office, IMB and duty director are all aware.*

5.288. On 27 May 2017 IS.91 RA Part C: Supplementary Information to IS.91 RA Part A completed by S Farrell recorded:

Use of force used to relocate [D1914] *to E Wing for his escorted removal during the use of force he stated that he would kill himself rather than return to Romania, Because of this threat he has now been placed onto ACDT Constant supervision and is now on Rule 40*

5.289. On 27 May 2017 at 21:30 Eddie Omoraka completed section 3 of the Report of Injury to Detainee form F213[73]:

[71] CJS004350 – Incident Report in relation to D1914, dated 27/5/17
[72] CJS001768 – Care and Separation – DCF 1 DC Rule 40 for D1914 dated 27/05/2017
[73] CJS004327 – G4S Report of Injury to Detainee for D1914, dated 27/5/17

BP 142/70 P 85 Sats 96%. Detainee have a removal directions, he was moved from C wing (his room) to E wing. He was not cooperative and handcuffs was safely applied. He later agreed to comply and walk escorted by officers to E wing. His handcuffs were removed and his body were assessed, there was no injuries sustained and no injuries reported by detainee during and after the removal to E wing.

5.290. On 27 May 2017 at 23:05 mental health nurse Edward Omoraka recorded in SystmOne[74]:

Detainee have an RD'S, he was moved from his room in C wing to Ewing. He was not corperative [sic] *initially and handcuff was safely applied. He later agred* [sic] *to comply and walk escorted by officers to Ewing. His handcuffs were removed and his body were assessed, there was no injuries sustained and no injuries reported by the detainee durinfg* [sic] *and after the movement to Ewing. His BP 142/70, pulse 85 and Sat's 96%. Form 213 was completed and given to Oscar 1. A copy was placed on the trail in healthcare.*

- In summary, there is a copy of an F213 contained within the SystmOne record [Page 222].

5.291. On 28 May 2017 at 09:52 nurse Emily Parr recorded in SystmOne:

History: Seen in EWING/CSU due to hand over to external escorts for flight - currently on constant watch. Examination: Did not require C & R, happy to walk to external escorts, and was removed from site, no C & R requried [sic] *from Brook house staff*

5.292. On 28 May 2017 at 16:40 nurse Emily Parr recorded in SystmOne:

Overview Notes
Attended for constant observation review. Very happy to be back, said his lawyer had given him bad advice. Denies having current thoughts or intent to hurt himself. Constant observations discontinued. Will remain on E wing for tonight, then all being well will be transferred back to to the main wings tomorrow.

[74] CJS000990 – Detainee D1914 Patient Record, dated from 29/3/2017 to 27/08/2017

Medication in healthcare pharmacy.
Overview Notes - returned from Failed flight, became agitated on the flight and the pilot decided it was not wise for him to be on the flight.

5.293. On 28 May 2017 at 19:50 Mr Callum Tulley completed a Security Information Report[75]:

My name is Detainee Custody officer (DCO) Callum Michael Tulley and I have been working live at Brook House IRC as an Activities DCO since the 15th of June 2015. At approximately 1930 hours I went to the visits hall to speak to my colleague DCO Dan Lake while I was on a toilet break from the library. He immediately drew my attention to detainee [D1914] *who was having a visit. Whilst I was in the visits Hall Mr.* [D1914] *recognised me from last night's restraint for which I was the shield officer. Although I was not required to use the shield I was required to engage in restraint with the detainee (please refer to extract below from my use of force report). Mr* [D1914]*kept on staring at me in the Hall and then became animated whilst saying things to his visitor. He was making gestures and appeared agitated. I found his behaviour to be intimidating; Due to this behaviour, last nights events and the detainees previous criminal history I now fear for my safety should I see him on association.*

5.294. On 05 June 2017 Removal Directions for 12 June 2017[76]

The Secretary of State hereby directs you to remove the above named person from the United Kingdom by W6 33112 to Romania at 07.35 hrs on 12 June 2017

- In summary, it is not clear from the records provided why these directions were not followed.

5.295. On 16 June 2017 Mr Paul Benson completed a three-month Detention review[77] which concluded:

[75] CJS004803 – Detention services security information report re incident on 28.05.17 re D1914
[76] HOM006952 – D1914 directions to remove a deportee dated 5 June 2017
[77] HOM006566 – Home Office Detention Review concerning D1914, dated 16/06/2017

- *'*[D1914] [redacted] *His presence in the UK is not deemed conducive to the public good taking into account the potential harm that lie poses to UK society. Removal has already failed once due to his disruptive behaviour and he has now lodged a JR which is now a barrier to his removal. However, Litigation have requested that the claim is expedited. If this is allowed and the JR is refused, then removal remains a realistic prospect within a reasonable timescale. I am satisfied that detention is proportionate and complies with guidance laid down in Chapter 55 of the EIGs. The risks associated with his release outweigh the presumption to liberty and I authorise detention for a further 28* ***days****'.*

5.296. On 05 July 2017 at 18:34 staff nurse Carol Reed Bishop recorded in SystmOne:

History: Seen by nurse
Diagnosis: called to E wing response call. Nurse Skitt, Nicola and myself in attendance [sic]. *Cuts to both arms and around neck. Taken all his i/p* [in-possession] *meds. Called for ambulance. Dressed wounds. 213 form to be completed by Skeet.*
Notes printed for Ambulance

5.297. On 06 July 2017 at 13:09 mental health nurse Karen Churcher recorded in SystmOne:

History: ACDT / Constant review
Examination: Seen in reception with Duty director M Brown, DCM C Donnelly, D.J RMN.
States he self harmed yesterday due to his bail being denied.
States he was upset but feels better now and realises it was not a good thing to do.
Does not wish to harm himself at present.
Would like to go back to C Wing but was asked to return to E wing and see the doctor and remain over night for observations.
Plan: Observation levels reduced to hourly and to review 7/7/17

5.298. On 06 July 2017 there is video footage which show an interaction between D1914 and Mr Tulley[78]

[78] BBC00583 – KENCOV1044 – V2017060600022: 06 June 2017, TRN0000018

- In summary, between 05:00 and 07:29, the footage shows D1914 explaining why he self-harmed and took an overdose. During the clip, D1914 is asked to show the wounds on both of his forearms and both sides of his neck by Mr Tulley.

5.299. On 07 July 2017 at 11:04 healthcare assistant Denise Wise recorded in SystmOne:

History: Went to E Wing applied dressings to both arms and neck to protect and cover wounds, advised detainee not to get wet, therefore not to shower but wash. SATS 98% PULSE 78bpm 113 / 70mmHg - detainee concerned as he does not have his discharge papers from ESH

5.300. On 07 July 2017 at 12:00 nurse James Newlands recorded in SystmOne:

History: ACDT review
Examination: Seen on wing with DCM C Donnelly.
Denied any current thoughts of self harm.
Is forward thinking for his next bail application.
Was given a copy of his discharge summary from hospital.
Requested to go back to C wing.
Plan: To be reviewed by GP and then to return to C Wing.
ACDT closed.

5.301. On 07 July 2017 at 16:04 Dr Saeed Chaudhary recorded in SystmOne:

History: Pt on medications will issue not in possession.
Pt mentions cut himself as he had hearing refused.

5.302. On 08 July 2017 at 09:01 nurse Donna Batchelor recorded on SystmOne:

History: Anxiety and fear
Examination: Detainee arrived very anxious into clinic
hyperventilating and high stress levels, detainee tearful
stated he was "unwell" no definate cardiac symptoms, due to previous history full observations taken and
documented.

SP02 99%
ECG taken- awaiting M/O [Medical Officer] *opinion*
Diagnosis: anxiety attack ?
Plan: to see MO as emergency appointment given
Pulse rate 80 bpm
135/87 mmHg

5.303. On 08 July 2017 at 13:47 nurse Edward Omoraka recorded on SystmOne:

Examination: SPO2 99%
resp 20 per minute
Plan: M/o to review
Pulse rate 78 bpm
143 / 94 mmHg

5.304. On 08 July 2017 at 13:58 Dr Saeed Chaudhary recorded on SystmOne:

History: Pt mentions not had medicines, woul dlike [sic] *me to chase hois* [sic] *operation date, advised will chase now on monday and number taken down for it. We will see f patient meds are here and the patient can take them.*

5.305. On 08 July 2017 at 18:09 nurse Donna Batchelor recorded on SystmOne:

History: asked to chase appointment for cardiac issues
Examination: appointment booked for aug 2017 letter with communication and letters please do not give detainee details of date of admission .

5.306. On 08 July 2017 at 22:55 staff nurse Lynn **O'Doherty** recorded on SystmOne:

History: Call from wing -detainee states he was asleep and unable to attend for medication. Went to his room to administer nocte medication. States he will attend pharmacy in future.

5.307. On 10 July 2017 at 06:34 nurse Janina Wingert recorded on SystmOne:

History: Called on the wing at 6:40 as detainee was having chest pain. When arrived detainee said that he can not feel his left arm and has chest pain
Examination: O/E - blood pressure reading 107.69, O/E - pulse rate 138 bpm.
Plan: Brought his morning medication and administered GTN spray. At 7 am [D1914] said that the pain is the same, did not subsided, BP 94/ 69, pulse 140. Ambulance called, ref no 26757257. Aiming to arrive in 8 minutes

5.308. On 10 July 2017 at 15:25 Miss Nicola Wells recorded on SystmOne:

History: returned back from hospital
discharge summary
medication in healthcare

- In summary, there was a discharge summary from East Surrey Hospital attached to the SystmOne record [Page 231].
- Although this is very brief, it does appear to indicate that an acute cause for **D1914's** chest pain that morning was not cardiac in nature.

5.309. On 13 July 2017 at 10:50 Dr Saeed Chaudhary noted in the SystmOne record[79]:

'History: Seen in health care 12.7.17. Discussed with nurse adn DR HO. pt at increased risk of cardiac problems. Have completed part C to be faxed to home Office. There is increased risk as he is presenting more frequently to helathcare complaining of cardiac type symptoms due to deterioration of mental health and general well being due to ***detention****'.*

5.310. On 13 July 2017, the IS.91 RA Part C (Revised)[80] completed by the GP, Dr Chaudhary on 13 July 2017 stated:

[79] CJS000990 – Detainee D1914 Patient Record, dated from 29/3/2017 to 27/08/2017
[80] HOM010916 – Home Office IS.91RA Part C - Supplementary Information Form dated 13.07.17

[D1914] *has multiple health issues which although initially stable are now at risk of worsening due to his detention. He has been to healthcare increasingly more due to his cardiac symptoms and I feel he is at risk of further cardiac issues should he have prolonged time in detention.*

5.311. On 17 July 2017 at 13:26 Dr Oozeerally noted in the SystmOne record:

'*History: Rule 35 done: medical* ***concerns****'.*

5.312. On 17 July 2017, the Rule 35 (1) Annex A report[81] completed by the GP, Dr Oozeerally for D1914 concluded:

This man has had two myocardial infractions and 2 coronary arterial bypasses. He is currently awaiting a cardiac catheter ablations for abnormal cardiac rhythm. He has intermittently complained of chest during his stay in detention and was recently sent to A&E as healthcare felt he had acutely deteriorated. It is felt that he is a high risk patient in view of his medical condition and that, though detention is not worsening his condition, the stress may trigger events that lead to another cardiac event.

5.313. On 20 July 2017 at 10:10 nurse John Owiti recorded on SystmOne:

History: Seen in Triage Clinic
Examination: Requesting to see GP
Reported not 'feeling good'
Reported experiencing pain on the upper part of his abdomen.
Kept on talking baoujt notfeelig [sic] *good and asking to see GP today.*
Wants to be referred to see doctor outside.
I have explained to him that I will dicuss his case with the GP as the GP ledger is full.
The GP would then decide
Hether [sic] *he wants to see him on Emergency.*
He was not able to listen to me.
Kept on demanding to see the GP, exposing his chest to me, showing me the scars

[81] CJS001024 – Home Office Rule 35(1) Report dated 17.7.2017

I explained to him that I am not saying he would not see the GP, only that I would need to speak to GP first and if
the GP wants to see him urgently then we would call him from the Wing
He threatened that if he does not see the GP he would smash his cell and he would self-harm
He then walked out, slammed the door hard, demanding to speak to the Manager
Vital obs done.
Seems to within normal range.
Plan: To discuss with GP this afternoon
Pulse rate 64 bpm
103/72 mmHg

5.314. On 20 July 2017 at 14:11 Dr Husein Ooozeerally recorded on SystmOne:

History: Seen on Wing.
He says difficulty sleeping but promethiazine [sic] *not helping.*
I have explained that no further sleeping tablets can be prescribed

5.315. On 25 July 2017 at 15:18 Dr Saeed Chaudhary noted in the SystmOne record:

'History: Spoke to patient, explained we have written to home office under rule35 for medical reasons and that we are waiting their decision. pt under stress and worried about dying, advised needs to remain calm and mentioned needs to contact solicitor as they would have received the rule 35 form home office if not then I will give a copy to the patient. Review again if needed. Paracetamol for any further ***pains****'.*

5.316. On 25 July 2017, the IS.335 letter[82] sent to D1914 by Paul Benson stated:

Dear [D1914]*, I am writing to you to acknowledge receipt of a report dated 17 July 2017, received on Friday 21 July 2017 provided by the medical practitioner at Brook House IRC Removal Centre notifying us of a special illness or condition. Information contained within the report has been considered carefully and as a consequence the decision to detain you is being urgently reviewed. If, as a result, a decision is taken to*

[82] HOM006799 – Home Office IS.335 Letter: Acknowledge Receipt of Healthcare Report dated 25.07.17

release you from detention, arrangements for and the conditions of release applicable will be communicated to you separately.

5.317. On 29 July 2017 at 08:42 nurse James Newlands recorded on SystmOne:

History: Refusing food Day 1
Examination: Sen this morning to compete physical health checks which he declined, stating that he was well and
okay and has been eating as normal.
BRAG rating; Green
Plan: Continue to monitor as required.

5.318. On 29 July 2017 at 09:07 Miss Nicola Wells recorded on SystmOne:

History: Came into healthcare very short of breath requesting BP to be checked
Stated he has no been sleeping last night as he [sic] *heart was beating very quickly*
Blood pressure taken 114/80 Pulse rate 70 bpm
ECG done by nurse and shown to MO
Appointment made for him to see MO

5.319. On 29 July 2017 at 14:56 Dr Husein Oozeerally recorded on SystmOne:

History: says ongoing pain, points to sternum and subcostal margin, says worse at night
Examination: pain when I press sternum and subcostal margin
Diagnosis: muscular /bony pain
Plan: codeine at night.
adv if SOB or CP or palpaitation s to seek urgent rev

5.320. In summary, the records provided indicate that following his arrival in Brook House, D1914 demonstrated quite impulsive, demanding and volatile behaviour at times which was initially adequately managed by the healthcare staff.

5.321. From a clinical perspective, there would be no immediate reason why a patient with the underlying cardiac history that D1914 appeared to be suffering with could not be adequately managed in the Immigration Removal setting.

5.322. However, there are two important observations to make. Firstly, the healthcare staff appeared to respond promptly and adequately to health-related concerns raised by D1914 during the period in which he was detained in Brook House. Secondly, that despite these efforts to provide adequate care, it proved to be increasingly difficult to continue the level of care owing to the additional stress placed on D1914 as a result of his ongoing detention. It appears that as D1914 became more agitated and escalated in his behaviour, healthcare staff became increasingly concerned that this may have an adverse affect on his underlying cardiac condition.

5.323. **D1914's** detention commenced at the end of March 2017 and continued until August 2017, a period of approximately four months. It is important to consider that this timeframe appeared to provide the healthcare staff a sufficient overview and understanding of the health needs of D1914 and the risks of ongoing detention in order to substantiate the views provided by Dr Oozeerally within the Rule 35 (1) report on 17 July 2017.

6. Opinion

Below, I have set out my preliminary opinion in regard to the areas I have been asked to consider:

6.1. Regarding the management of healthcare staff, the relationship between healthcare and other entities in Brook House, whether appropriately qualified clinicians were employed, and whether they received adequate training:

6.1.1. The management of healthcare staff

6.1.1.1. In the documentation I have reviewed so far, I have found no evidence of poor management of healthcare staff. There is evidence of staffing issues and significant vacancies[83][84][85][86]. Workforce recruitment and retention is a common and longstanding issue within the Health and Justice settings. There are a number of internal and external factors that contribute to the challenges for the recruitment and retention of nursing and medical staff working in immigration removal and prison settings.

6.1.1.2. From an external perspective, there is no routine exposure embedded within undergraduate nursing or medical training to the potential opportunities for working in prison or immigration removal centres or the needs of these patient groups and as a result, there is often only small pockets of interest developed on a local basis. From a post-graduate perspective, there is also very little in the way of any specific education or training resources directed at people wishing to work

[83] CJS004274 – G4S Policing Support and Healthcare Service: Contract Level Clinical Governance (Meeting minutes), 18 December 2017
[84] CJS004281 – G4S Policing Support and Healthcare Service: Contract Level Clinical Governance (Meeting minutes), 20 November 2017
[85] CJS004283 – G4S Contract Level Clinical Governance (Healthcare) - Meeting Minutes, 21 February 2018
[86] CJS000527 – G4S Health Quality Committee Meeting Minutes at Brook House IRC, 31 October 2017

in secure environments and there is nothing obligatory beyond the standard mandatory training that would be expected of a suitably qualified professional, such as basic life support, child protection training, health and safety, infection prevention control etc.

6.1.1.3. From an internal perspective, it is well recognised that new staff entering the environment who have undertaken specialised training in other settings, such as hospitals and the wider community will often experience significant skill fade. Working in secure settings does require its own set of skills which are frequently acquired whilst in role. As a result, recruitment into these roles can be challenging and retaining new staff can also be affected by these pressures.

6.1.1.4. A number of policies have been made available to me which are in keeping with subjects I would expect to see within the secure setting, for example including but not limited to use of force, substance misuse and others relating to the specific Detention Centre Rules.

6.1.1.5. The video footage and medical records I have been provided showed that in the majority of cases, these policies and procedures were being adhered to by the healthcare staff and appeared to demonstrate that in the main there was a positive culture in regard to the use of the polices in place. The most significant exception to this observation was the in relation to the incident involving D1527 on 25 April 2017 when nurse Buss failed to intervene in regard to the Use of Force.

6.1.1.6. On the evidence reviewed so far, I am not able to comment further on the day-to-day management of the healthcare service within Brook House Immigration

Removal Centre and have provided this as a preliminary view pending receipt of further documentation.

6.1.1.7. The video footage I have reviewed has provided some insight into the level of skill of the nursing staff, particularly in responding to intoxicated patients[87,88,89,90,91]. In the majority of cases, this showed an adequate response in terms of the initial approach to observation and management of acutely intoxicated patients. However, on occasion, the footage did reveal some inappropriate behaviour by some of the healthcare staff when dealing with the detained persons which appeared to be sarcastic or mocking in nature suggesting a level of disdain for the detained person. The video footage also captured some of this behaviour being exhibited by some of the detention staff[92].

[87] TRN0000033– 04 July 2017
[88] TRN0000083 (pages 1-12) 19 June 2017
[89] TRN0000093 (pages 9-14) 15 June 2017
[90] TRN0000095, (pages 45-51) 13 May 2017.
[91] TRN0000095 pages 9-17,13 May 2017
[92] BBC000093 – KENCOV1035 – V2017061400015 – 14 June 2017: 00:05-30:00, TRN0000092 pages 34-45.

6.1.2. Relationships between healthcare and other entities in Brook House

6.1.2.1. The evidence I have been provided does not demonstrate any areas where there was an inadequate or dysfunctional relationship between healthcare and the other entities in Brook House. This is a preliminary view until such time that I receive further documentation allowing me to comment further on this aspect of the Inquiry. The video footage does provide some insight into the interaction between healthcare and detention centre staff and broadly speaking, there is a theme of cooperation and support in responding to the various incidents. The video footage largely comprises incidents in which healthcare staff are responding to '**emergencies**', such as intoxicated patients; where there has been or will be a use of force and/or acts of self-harm or attempted suicide.

6.1.2.2. From a clinical perspective, I saw video footage[93][94] that demonstrated a number occasions where healthcare staff were responsive and helpful in their approach to dealing with incidents and emergencies when contacted by custodial staff. In a number of cases, more than one nurse would attend, they would apparently arrive promptly and prepared with the necessary equipment and would commence their work with the detained person.

6.1.2.3. From a management perspective, the evidence provided to me so far demonstrated an adequate spirit of collaboration and understanding of the needs of the respective components of the teams working in Brook House which was in keeping the collective duty of care. This is a preliminary view until such time that

[93] TRN0000027 pages 10-11 18 May 2017
[94] TRN0000093 pages 9-14 15 June 2017

I receive further documentation allowing me to comment further on this aspect of the Inquiry.

6.1.2.4. On one occasion, there was video footage evidence[95] of the apparent failure by nurse Joanne Buss to adequately challenge a member of the custodial team in the use of excessive and inappropriate force on a detained person D1527 on 25 April 2017 and subsequently, there was failure to record this on the appropriate form F213 or within the **patient's** record[96] (although the F213 was recorded by nurse Makucka). From the footage provided, this appeared to be a very serious breach of duty by nurse Buss given her apparent failure to intervene in the excessive Use of Force on D1527 and disregard for his welfare during this incident. This is a preliminary view based on the material provided to date and until such time that I receive further evidence that assists in providing further perspectives on this incident. This was the only serious failing identified through the video footage I have been provided, and it was of such a serious nature so as to require referral to the Nursing and Midwifery Council (the regulatory body for the nursing staff) for their consideration as to nurse **Buss's** fitness to practise.

[95] BBC000071 – KENCOV1007 – V2017042500021 – 25 April 2017: 00:00-27:49, TRN0000002
[96] CJS001002 – Patient Record of D1527 beginning 16.11.2016 printed 28.4.2020

6.1.3. Whether appropriately qualified clinicians were employed

6.1.3.1. I have not, at this stage, been provided with the NHS Service Specification for the provision of healthcare within Brook House during the relevant period. This document would be helpful in providing an overview of the NHS **Commissioner's** expectations in regard to the nature and level of services to be delivered by the contracted provider. The Service specification may also be helpful in outlining the key performance indicators being monitored as part of the contract review process. From the material provided to date, I have not been able to form a view on the overall performance of the contracted provider in this context.

6.1.3.2. Based on the documentary and video footage evidence, it is my view that, broadly speaking, the healthcare staff working in Brook House appeared to be appropriately qualified to undertake the work they were doing, including both nurses and GPs. This is a preliminary view until such time that I receive further documentation allowing me to comment further on this aspect of the Inquiry.

6.1.3.3. I have not been provided with any evidence to date indicating that any of the staff were inadequately qualified however, I reserve this position pending sight of further material which may confirm or alter this position.

6.1.3.4. That said, as I have indicated below, the duties of both nurses and GPs working in the Immigration Removal Centre settings does require additional knowledge and skills that are not ordinarily obtained through general nursing or medical training.

6.1.3.5. I was not provided with evidence that described a comprehensive approach to the induction and training of new staff prior to the commencement of their work within Brook House. This is often the case for new staff working in secure settings because of the pressure and requirement to fulfil a function of being 'on duty' whilst not having sufficient staffing resource to allow for the new starter to work in a supernumerary capacity in order that they become familiar with the additional knowledge and skills necessary for their role.

6.1.4. Whether staff were appropriately trained

6.1.4.1. In general terms, I found some evidence of inadequate training of healthcare staff. This appeared to be particularly highlighted by the GPs and regard to the use of Rule 35 (1), Rule 35 (2) and Rule 35 (3). In my view, inadequate training is not unique to Brook House but is often commonplace and consistent with undertaking work in a secure setting where many of the distinct aspects of healthcare provision are learned '**on** the **job**'. New staff are often exposed to the nuanced aspects of delivering healthcare in the secure setting without any form of prior experience. Even where policies and procedures exist, many of these are often not routinely supported by bespoke training and insufficient time is provided to fully understand them in the context of the care being provided. Where bespoke training does exist, it is often the case that this is not provided frequently enough to accommodate the turnover of new staff and/or use of agency staff. It is also recognised that policies and procedures may need to be changed as a result of learning from incidents or as guidance changes and therefore training also needs to be provided on a cyclical basis to ensure skills are kept up-to-date.

6.1.4.2. It is well recognised that specific training for many of the unique aspects of healthcare work required in secure and detained settings is rudimentary or non-existent. For example, there is no systematic approach to the exposure of nurses or doctors (GPs) through their respective vocational training programmes to exposure to the work in Immigration Removal or prison settings. It is also well-recognised that this is one of the factors that contributes to the challenges of workforce recruitment as there is no clear path in terms of career advancement and progression.

6.1.4.3. GPs and nurses will invariably have worked in hospital and/or primary care settings as part of their post-graduate training and will bring a variety of skills when coming to work in secure and detained settings. On the one hand, this is important for bringing the skills and competencies of healthcare staff into the Immigration Removal setting and adhering to the principle of providing '**equivalent**' care to detained persons. On the other hand, there are, however, no prerequisite standard courses or training modules that must be completed to work in these settings. It is widely accepted that the enforcement of pre-employment '**certification**' or training requirements necessary to work in secure and detained settings could result in significant barriers to timely and successful recruitment into roles within their establishments.

6.1.4.4. I have not, at this stage, seen a specific induction programme or timetable for newly appointed staff. There was one document, the G4S Gatwick **IRC's** & Cedars Welcome Pack[97] which is helpful in describing an overview of the service being provided and an outline of duties and responsibilities.

6.1.4.5. I have been provided with a number of documents relevant to in-post activities:

- Violence Reduction Strategy[98]
- Suicide Prevention and Self-harm Management[99]
- Safeguarding Policy[100]

[97] CJS006391 – G4S Justice Health Gatwick IRCs Welcome Pack, undated
[98] CJS000721 – **G4S Gatwick IRC's Violence Reduction Strategy, 19 August 2015**
[99] CJS006380 – G4S Gatwick IRCs Policy Document on Suicide Prevention & Self-Harm Management; reviewed date, September 2016
[100] CJS006379 – G4S Gatwick IRCs Safeguarding Policy, 09 May 2013

- Guidance for staff managing detainees on Constant Observations[101]
- Management of Adults at Risk in Immigration Detention[102]
- Introduction to Safer Custody, Gatwick IRC's Caring for Detainees at Risk[103]
- Enhanced Mental Health Training, Gatwick IRCs Caring for Detainees at Risk[104]
- E Wing Policy[105]
- Removal from Association (Rule 40) - Plus Annex B Initial Health Assessment and Care Map[106]
- Temporary Confinement (Rule 42)[107]
- Food & Fluid policy (and Form)[108]
- G4S monitoring of patients during and after restraint 01/08/2016[109]

6.1.4.6. Broadly speaking, these policies cover the range of topics that would expect to see for healthcare practitioners working in this type of setting and they largely contain the level of detail necessary for undertaking their role. It is not clear to me how readily these were accessible to the staff.

6.1.4.7. I have not been provided with an outline of the process for how these policies were systematically reviewed and updated in order to maintain their currency, for

[101] CJS006378 – G4S Gatwick IRCs Guidance for staff managing detainees under constant supervision, May 2019
[102] CJS000731 – Home Office Detention Services Order 08/2016 on Management of Adults at Risk In Immigration Detention, February 2017 v1.0.
[103] CJS000052 – G4S Introduction to safer Custody, Gatwick IRC's Caring for detainees at Risk. Safer Community Team at Gatwick IRC's handbook, undated
[104] CJS000020 – Enhanced Mental Health Training, Gatwick IRCs Caring for Detainees at Risk
[105] CJS006043 – G4S E Wing Policy; last updated September 2018
[106] CJS006040 – G4S Draft Removal from Association, Safeguarding, undated
[107] CJS006041 – G4S Temporary Confinement, operational instructions, last reviewed September 2016 (DCF 3 Form not attached)
[108] CJS006084 – G4S Operational Instructions, Food & Fluid Policy, 01/09/2018
[109] CJS007047 – G4S monitoring of patients during and after restraint 01/08/2016

example, as a result of any new guidance or learning from incidents or events. Additionally, where policies were developed or updated, it is not clear how these were cascaded to healthcare staff to ensure their awareness and understanding necessary for maintaining competency in these areas.

6.1.4.8. The Contract Level Clinical Governance meeting[110,111,112,113] and Senior Nurse meeting[114] documents provided highlight many of the challenges in terms of staff vacancies, proportion of agency staff and challenges in maintaining adequate levels in regard to mandatory training.

6.1.4.9. I have not been provided with the full list of mandatory training requirements for healthcare staff working in Brook House, but my expectation is that these would be consistent with the mandatory training requirements applicable to all healthcare staff working in the NHS. The documents above outline some of these training needs, such as Basic and Intermediate Life Support, Safeguarding, Equality and Diversity and Health and Safety training (there are others). The minutes of these meetings also reflect the challenges in keeping staff up-to-date in all of these areas. This is a common challenge in secure settings where pressure on staff to be on active duty, lack of resource for staff to cover for absence whilst training and other pressures can be disruptive to ensuring all staff are current in all these areas.

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[110] CJS004281 – G4S Contract Level Clinical Governance (Healthcare) - 20/11/2017
[111] CJS004283 – G4S Contract Level Clinical Governance (Healthcare) - Meeting Minutes - 21/02/2018
[112] CJS004274 – G4S Policing Support and Health Services: Contract Level Clinical Governance (Meeting Minutes)
[113] CJS000527 – G4S Health Quality Committee Meeting Minutes at Brook House IRC, 31 October 2017
[114] CJS004282 – G4S Health Service - Senior Nurse Meeting (12/01/2018)

6.1.4.10. Based on the documentary evidence provided so far, it is apparent that there were both Registered General nursing staff (RGN) and Mental Health Nurse (RMN). This is typical for the provision of care in a secure setting given the recognition of trying to address both the physical and mental health needs of the persons being detained. There is no formula for ensuring the correct ratio of RMN and RGN nursing staff and I have not been provided with a breakdown of the overall numbers working in Brook House at the relevant time. In my experience, it is often a challenge for providers to ensure that an appropriate skill mix is on duty across a rota at all times given shift patterns, annual leave, use of agency staff and other factors which can affect the overall staffing timetable. These factors can then have a further impact on the level and type of skill and experience able to respond to different types of incident whilst on duty at any given point in time.

6.1.4.11. The documents provided clearly indicate that there was a significant reliance on the use of agency staff as result of a number of staff vacancies. This is a common challenge for providers within the secure and detained estate. Agency staff will frequently possess a range of skills, experience, interest and understanding of this area of work which is often inconsistent and/or unpredictable to the manager organising the rota. This further complicates the issue of trying to ensure the '**right**' type and level of coverage is provided consistently on each shift.

6.2. Regarding the effectiveness of assessing vulnerability at Brook House in the relevant period. In particular the operation of Rules 34 and 35 of the Detention Centre Rules 2001, and the efficacy and use of the Adults at Risk policy:

6.2.1. Effectiveness of assessing vulnerability

6.2.1.1. The Detention Services Order 08/2016 Management of Adults at Risk policy[115] sets out the factors and experiences which would be considered to contribute a detained **person's** risk of vulnerability within the Detention Centre. I have set out the relevant aspects of this policy in paragraphs 5.9 – 5.11 above.

6.2.1.2. Broadly speaking, a patient who is unable to take care of themselves or protect themselves from harm or exploitation is considered '**vulnerable**'. There are many possible factors that may influence a **person's** vulnerability and these may also be dynamic. Factors such as learning difficulties and disabilities are likely to be consistent and unwavering in their propensity to cause a person to be in a vulnerable state. Behaviours as a result of the use of illicit substances and/or fluctuations in underlying mental health conditions may be more fluid and fluctuate in how they impact on a **person's** level of vulnerability over a period of time. In many cases, individuals may well have a number of these factors contributing to their overall level of vulnerability at any given time. It is often considered that these patients are considered to have '**complex**' needs and as a result they will need the medical input of a number of components of the healthcare provision, for example, the support of the mental health team, substance misuse as well as

[115] CJS000731 – Home Office Detention Services Order 08/2016 on Management of Adults at Risk In Immigration Detention, February 2017 v1.0

primary care. It is considered best practice to discuss the needs of vulnerable individual with complex needs in a multi-disciplinary (multi-professional) forum in order to coordinate an appropriate care plan. In secure and detained settings, this will often involve the custodial staff who are likely to see the person on a daily basis.

6.2.1.3. Caring for individuals with complex needs can be time-consuming, emotionally challenging and resource intense for both detention and healthcare staff. Repeatedly having to deal with volatile, aggressive, confrontational and/or seemingly manipulative individuals can lead to compassion fatigue and desensitisation. Desensitisation within secure and detained settings is very common and very hard to eradicate once embedded and can impact on how '**vulnerabilities**' are recognised and addressed.

6.2.1.4. Frustration and resentment can be felt by staff that their time and energy is absorbed having to attend to the needs of the few, more complex people rather than being able to help the others who they may feel are more in need. The video footage I have seen demonstrates some of this frustration, more so by custodial staff, who are seen to mock some of the detained persons.

6.2.1.5. The Safeguarding policy[116] in use at Brook House is concerned with matters of child protection. This policy does not make reference to the Management Adults at Risk in Immigration Detention. I have not been provided with an Adult Safeguarding policy in use at Brook House at the relevant time. Conversely, the

[116] CJS006379 – G4S Gatwick IRCs Safeguarding Policy, 09 May 2013

Detention Services Order 08/2016 Management of Adults at Risk in Immigration Detention does not specify in any detail how detained persons who have been identified as being '**at risk**' ought to be managed in terms of an adult safeguarding pathway.

6.2.1.6. The West Sussex Safeguarding Board undertook a Learning Review[117] in relation to detained person following a referral by a member of staff in their Safeguarding Unit in July 2017 by the detained **person's** legal representative. It is of note that the Board identified in their review that the Detention Services Order 08/2016 does not specifically refer to adult safeguarding. The recommendations made by the West Sussex Safeguarding Board[118] include under 5.1 a suggested '**review**' of DSO 08/2016 should take place but does not specify in detail what aspect(s) should be reviewed per se.

6.2.1.7. It stands to reason that some of the individuals who are deemed to be 'at risk' according to the DSO 08/2016 and/or who have suffered some form of harm or exploitation would meet the relevant threshold and should otherwise be referred through the local Adult Safeguarding team. However, that is not to say that all persons with vulnerabilities identified through DSO 08/2016 ought to be referred to the Adult Safeguarding team. In my view it would be helpful to consider whether the Detention Services Order should be more explicit in taking into account the adult safeguarding needs and pathways of referral for detained persons deemed

[117] WSS000001 – Brook House Learning Review concerning unnamed detainee, dated 9th May 2018
[118] WSS000005 – WSSAB MA learning review action plan from recommendations

to be particularly vulnerable or '**at** '**risk**' whilst in detention and also when considering the possibility of release from detention as a result of this status.

6.2.2. Operation of Rule 34

6.2.2.1. From the records reviewed, detained persons were routinely assessed through the reception screening questionnaire on arrival into Brook House and this was in keeping with the expected standard across the immigration removal estate and aligns to the process for first night reception screening within the prison estate.

6.2.2.2. Within the prison setting, the NICE Clinical Guideline NG57[119] – Physical Health of People in Prison sets out a two-stage process for the assessment of new arrivals into prison. Whilst this Guideline does not specifically apply to persons detained within the Immigration Removal estate as they fell outside of the scope of the guideline development, it does describe a '**first**' and '**second**' stage approach to the systematic screening and detection of health issues and other needs for an individual promptly after arrival in to the secure estate.

6.2.2.3. The first stage or 'reception' screening is intended to obtain a combination of subjective and objective information from the detained person with the aim of establishing the immediate and ongoing medical needs following arrival at the Immigration Removal Centre.

6.2.2.4. The primary focus of this 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. For example, immediate risks may include overt plans to self-harm or act on suicidal plans, prescribing of medication that if missed could lead to

[119] NICE Guideline NG 57 - Physical Health of People in Prison – November 2016 [https://www.nice.org.uk/guidance/ng57]

significant health consequences (e.g. anti-epileptic medication) or the acute management of drug and/or alcohol withdrawal.

6.2.2.5. Routine enquiries within the reception screen aim to establish from the detained person their knowledge of their own past medical history, medication and any other perceived medical needs. Further to this enquiry, the nursing staff will aim to gather a number of objective elements during their assessment in order to both corroborate what they have been told by the detained person and to detect any new or emerging issues. For example, this might include checking the weight and blood pressure but also making an assessment of their mental state through observation of their demeanour. This information should be recorded on the electronic health record (**TPP's** SystmOne [120]) in order to create a contemporaneous clinical record.

6.2.2.6. In the prison setting, the first and second stages of the screening are intentionally split in order to ensure persons who are newly arrived in the establishment are not overwhelmed with too many enquiries. A balance needs to be struck between gathering sufficient information that the healthcare team needs to identify immediate risks versus the recognition that a detained person may want to settle in after their period in custody elsewhere (e.g. Court or Police) and their journey to the establishment.

6.2.2.7. Second stage screening in the prison setting is intended to be completed within the first seven days after arrival in the establishment and is primarily intended to

[120] The SystmOne record is a confidential electronic healthcare record and is not accessible to Detention centre staff.

review the initial period of custody and to consider whether there are any additional health needs that should be investigated going forwards. For example, this process would aim to ensure that medications prescribed in the community had been prescribed where appropriate and the opportunity taken to consider whether blood tests might be needed for the screening of long-term conditions, such as type 2 diabetes.

6.2.2.8. Rule 34 is essentially conducted through the reception screening process described above and recorded through the use of a template on SystmOne. All of the case studies I reviewed demonstrated that there was a consistent approach to this initial screening process and as such it appears that Rule 34 was being appropriately carried out adequately. Although I have noted reference to '**second stage**' screening in the records, it is not clear whether this was being undertaken systematically or not and if so, whether there was a template in use at that time[121].

[121] In 2018, North East London Commissioning Support Unit (NELCSU), who were commissioned by NHS England to provide development and training to the Health & Justice providers within the secure and detained estate rolled out a standard set of templates for use in the Immigration Removal Centres (Except Dungavel in Scotland). These included **'arrivals screening', 'secondary screening', 'in-possession risk assessment', 'medicines reconciliation' and 'release and transfer out' templates as well as a number of others**.

6.2.3. Operation of Rule 35

6.2.3.1. Broadly speaking, and on initial inspection, the system for the undertaking of a Rule 35 (1) and (3) reports appeared to be adequate. I have reached this conclusion on the basis that detained persons were apparently assessed or provided with opportunities to see the GP within Brook House upon request or when particular needs were identified. In regard to Rule 35 (3), I have seen documentary evidence that detained persons were seen by the GP with the specific purpose of discussing and assessing their Rule 35 (3) requirements and this would be recorded on the appropriate form and an entry made in the SystmOne records.

6.2.3.2. It was not clear that there was a defined or consistent approach for detained persons who either wanted or required a Rule 35 (3) report. For example, it was not explicit whether the Rule 35 (3) reports were conducted following self-referral by a detained person, detection by Brook House detention or Healthcare staff based or on identified concerns through Home Office or Legal Representative requests or a combination of these options or any other routes.

6.2.3.3. That said, in my opinion, having reviewed the available documents, that there are a number of weaknesses that potentially undermine this process and the Adults at Risk policy. The detainee focus groups that contributed to the Verita report[122][123] highlighted potential issues around the true independence of the GP undertaking

[122] VER000202 – 81 – Detainee focus group 2 notes – Copy
[123] VER000204 – 83 – Detainee focus group 1 notes – Copy

the Rule 35 (3) reports as well as whether the GPs possessed sufficient qualification to undertake these assessments.

6.2.3.4. It is apparent that GPs undertaking Rule 35 (3) reports face a number of challenges. I found only basic evidence[124] of specific ad hoc training given to the GPs in respect of the assessment of detained persons who may require a Rule 35 (1) or Rule 35 (3) report. The agenda for the training carried out on 18 January 2016 included a presentation on the use of the relevant forms[125], a presentation by Dr Alan Mitchell[126] on *'An IRC GP perspective'* and a presentation by Dr Rachael Pickering[127] on *'Documentation of injuries'*. I have not been provided with the detail of the content of each these presentations and will reserve further comment at this stage. However, I am aware that both Dr Mitchell and Dr Pickering are considered experts in the field of healthcare in secure environments.

6.2.3.5. Broadly speaking, in my opinion, the quality of the '**medical**' aspect (as described in paragraph 5.32 above) of the Rule 35 (3) reports was adequate. The reports that I reviewed demonstrated that GPs took an appropriate history from the detained person and recorded this both within SystmOne and within section 4 of the Rule 35 (3) reports. Subsequently, examination findings were also recorded

[124] CJS007033 – Staff training agenda, 18/01/2016
[125] HOM002581 – PowerPoint presentation: Detention Centre Rule 35 Date: October 2015
[126] I have a longstanding professional relationship with Dr Alan Mitchell through my work as the Chair of the Royal College of General Practitioners Secure Environments Group (SEG) and as an Expert contributing to the work of the Council of Europe Committee for the Prevention of Torture (CPT). Dr Alan Mitchell is the UK member and current President of the CPT. I am aware that Dr Mitchell has extensive experience of working in Dungavel IRC and has contributed to work in this are with the Home Office. Dr Mitchell attends the quarterly RCGP SEG meetings
[127] I have a professional awareness of Dr Rachael Pickering through her work as a Chair of the British Medical Association Forensic and Secure Environment Committee (FSEC).

in section 5, and in an adequate manner, where appropriate. Of the Rule 35 (3) reports I reviewed, there were no clear examples where the GP provided an inadequate history or examination within section 4 or 5.

6.2.3.6. As I have set out above in paragraph 5.47, it is my view that the system for undertaking Rule 35 (3) reports appears to fall down within the formulation of the findings within section 6 of the report. It appeared that there was an inconsistent approach to the relevance and understanding of the purpose of this section by the GPs. For example, it was unclear whether the emphasis was on providing clarity on whether the detained person had in fact suffered some form of ill treatment and whether or not this previous experience was in some way contributing to a deterioration in the detained **person's** mental health whilst remaining within the immigration removal setting. As I understand the policy, it is this latter point that causes the most confusion and in my view, results in a significant proportion of the reports that I have seen being inadequate as they failed to record their view in regard to the likely impact of detention. There were examples where there may be detained persons who have had significant experience and evidence for past ill treatment in whom the presenting medical evidence indicated that being detained within Brook House was not being adversely impacted. Conversely, there may have been detained persons whose available history and examination findings demonstrating their past ill treatment may be less clear but the effect of detention is contributing to a deterioration in their mental health but would not have been subject to a Rule 35 (3) report process.

6.2.3.7. Ultimately, Rule 35 (3) reports are submitted to the Home Office and these feed into their decision-making in regard to the need for ongoing detention (or not) during their further investigations and resolution of the case. The information provided within these reports is apparently weighed in conjunction with other evidence and material available only to the Home Office case workers. It is possible to see these responses within the case histories above where an IS.335 letter has been provided by the Home Office in response to a Rule 35 (3) report.

6.2.3.8. As I understand it, the approach to the Human Rights [Article 3 ECHR] aspect of immigration detention, is that any person who has apparently been subjected to ill treatment in the past is considered at risk of further deterioration should they be placed in a detention environment and this should be avoided where possible. This suggests to me that where there has been a past history of ill-treatment (and a Rule 35 (3) report completed), whether or not there is perceived deterioration during detention should not necessarily be considered as a deciding factor as to whether continued detention should be authorised. The '**medical**' component of the information provided within the Rule 35 (3) reports appears to be overruled by the '**immigration**' factors in the cases that I reviewed.

6.2.3.9. As a detained **person's** past history of exposure to ill treatment is not always known about, it stands to reason that there should be a system for screening for this information and that a formal system of reporting should be in place where possible. The Adults at Risk policy goes some way towards doing this and furthermore defines the categorisation of the levels of evidence gathered in the process of providing a Rule 35 (3) report. It is understood that some people may

be reluctant to share their past history with professionals that they view as being in a position of **'authority'**, where this be as a result of mistrust, fear and/or shame.

6.2.3.10. It is the role of the Home Office to collate all of their available information, including the **person's** past immigration history, past offending history, immigration status and their current detention process and to come to a conclusion on whether the risks (e.g. to the public or to absconding) associated with releasing the detained person from the immigration detention centre outweigh the benefits and therefore whether detention should continue. Decisions like these are also subject to dynamic influences, including but not limited to the time in detention, the conclusions in regard to the immigration process, with or without deportation, as well as the impact that detention invariably has on mental health overall. As such, the provision of a Rule 35 (3) report does not readily offer a dynamic approach to re-assessment or review. In the event that a detained **person's** circumstances change, it is not clear that a review of the Rule 35 (3) process is triggered automatically.

6.2.3.11. It is notable that within the case studies for D1527 and D1914 I could not find a completed Rule 35 (2) report despite their respective episodes of significant self-harm. This raises a question as to whether this process is underutilised for such cases, but this is a preliminary view pending receipt of any further documentation.

6.2.4. Efficacy of use of Adults at Risk policy

6.2.4.1. It is not entirely clear to me how it is determined whether a detained person requires a Rule 35 (3) report and whether there is a consistent approach. In some cases, it would appear that self-referral, request through the legal representative or request by the Home Office are potential routes. Although I am not aware, there may be other prompts to undertaking a Rule 35 (3) report.

6.2.4.2. Factors to consider:

6.2.4.2.1. It is not clear whether the process for providing Rule 35 (3) reports was working differently in Brook House IRC versus other Immigration Removal Centres[128] and importantly whether or not this information is gathered and reviewed by the Home Office as part of a quality assurance process.

6.2.4.2.2. As outlined above, there are a number of issues that appear to affect the Adults at Risk policy within the detention setting:

- the competency and consistency of the GPs;
- the relative independence of the GPs;
- the availability of resources including, for example, sufficient time for an appropriate assessment and/or sufficient time for the use of translation services;
- the interpretation of the task of providing a Rule 35 (3) report;
- the adequacy of the report itself.

[s] As set out above, four of the Rule 35 (3) reports I reviewed do appear to have been undertaken in other Immigration Removal Centres.

6.2.4.3. It is not clear whether there is a designated process within the Home Office for quality assurance, quality improvement and feedback arising from Rule 35 (3) reports. Whilst it is possible to see some of the bilateral communication within the case studies, it is not clear whether the information is shared consistently with relevant stakeholders, including the detained person, in what manner it might be shared and importantly, what actions are taken as a result. For example, following the provision of a Rule 35 (3) report, it is not clear whether the IS.335 letter of response from the Home Office is routinely provided to or reviewed by the GP who completed the original report. Furthermore, where the case studies show that the healthcare provider has received a copy of the IS.335 letter of response, it is not clear whether there is any system in place for reviewing the detained person in response to their presumed receipt of the same letter. This would appear to be particularly relevant in respect of cases D1527, D1538 and D1914.

6.2.4.4. As I have set out above, it is my opinion that GPs are not normally adequately skilled to provide an opinion or make a determination on the validity or otherwise of the information provided to them by a detained person in respect of ill-treatment or torture, whereas many of the other features listed within the Adults at Risk policy I would expect to be readily identifiable by a GP. Aside from past ill treatment or torture, I did not come across any Rule 35 (3) reports that were completed by GPs in respect of any of the other issues, such as serious physical disability, being aged over 70 or being a transexual or intersex person. The case study for D1914 included the completion of a Rule 35 (1) report by Dr Oozeerally in respect of his underlying cardiac issues.

6.2.4.5. As I have described above, one of the most significant inadequacies in the completion of the Rule 35 (3) reports was the limited completion of section 6 by the GPs, specifically in respect of the impact of ongoing detention. As I have outlined above, this determination could, in any case, be very difficult to predict for a number of reasons, given the limited time in which the detained person was known within the centre, in the absence of specific training and an appropriate level of experience or training of the GP (which I would not routinely expect a GP to possess).

6.2.4.6. Although it falls outside of my instructions, it is noted that the Adults at Risk policy has been reviewed on a number of occasions and the latest version[129] does include reference to different '**evidence levels**' on page 12. These levels may be useful for the caseworker who is assessing the weight to the information received within the Home Office, but it does appear that this could be somewhat confusing when considering the Rule 35 (1) and Rule 35 (3) reports provided to them given that the GPs often did not comment on the impact of detention.

6.2.4.7. In my opinion, a review of the Adults at Risk policy in conjunction with the Detention Centre Rules 34 and 35 needs to be undertaken to ensure a better approach is established for detection of vulnerability and pragmatic approach to the consideration of the use of detention.

[129] Adults at risk in immigration detention, Version 5.0, March 2019

6.3. Regarding the extent and suitability of the health provision, particularly mental health provision, medication and prescription management, the clinical management of self-harm and food and fluid refusal, and the relevance, if any, of substance misuse in the treatment of detainees:

6.3.1. The extent and suitability of health provision

6.3.1.1. I have not been able to explore the overall suitability of the whole of the health provision within Brook House and would suggest that the recent report[130] of Her **Majesty's** Inspectorate of Prisons (HMIP), who work in collaboration with the Care Quality Commission (CQC) are most appropriately placed to determine the overall suitability of the health service being provided against their standards.

6.3.1.2. In relation to the healthcare service, I would expect NHS England, who commissioned the service, to be holding regular meetings with the provider with specific reference to meeting the service specifications of the contract and monitoring of the overall quality of the service. At the time of writing this preliminary report, I have not received sufficient evidence to reach a final view on the contractual monitoring of the service provision by NHS England.

6.3.1.3. In my opinion, the evidence I have been provided with to date did not raise concerns that the overall extent and suitability of the health provision was inadequate during the relevant period.

[130] Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons, March 2017

6.3.2. Mental health provision

6.3.2.1. I have not been able to explore the overall provision of mental health services within Brook House. As above, I would expect HMIP and CQC to consider this within their role as inspectors. Again, I would expect commissioners to be monitoring the overall quality of the service provision and whether it meets the terms set out in the service specification.

6.3.2.2. It is important to note that the term '**mental health**' comprises a wide spectrum of presentations. At the lower end of the scale, more common and mild to moderate levels of anxiety and depression are most appropriately and reasonably addressed by the primary care services (equivalent to what we would see in the community). At the highest of the scale, there is severe enduring mental illness and severe acute deteriorating mental illness that would require the assessment and management of the secondary care specialist psychiatric services, and in some cases, transfer to psychiatric facilities outside of the detention centre. In my experience, it is common to find a significant '**middle**' group of people who fall between the two ends of the spectrum and who are too complex for primary care but do not meet the threshold for in-reach secondary care specialist services. This broad '**middle**' group of people are overrepresented and commonly recognisable in secure and detained settings. In my experience, services within these settings are often least well equipped to address this group of people. This is frequently down to one or more factors including poor access to relevant therapies, possible underlying personality disorders (frequently considered to be untreatable), behavioural disorders and poor behavioural and coping strategies. In particular, this group are frequently detained (or incarcerated) down to these behaviours,

often aggravated by ongoing substance misuse (and/or alcohol), frustration with authority (including ongoing detention and/or fear of deportation), language barrier and paucity of hope in regard to resolution of detention and legal processes.

6.3.2.3. The case study of D720 appears to demonstrate some of these challenges. On arrival in Brook House, D720 makes a clear assertion that he suffers with a number of physical and mental health issues and that he should be prescribed certain medications should be prescribed as a result. However, upon receipt of the community GP records, this reported history was shown to be inaccurate. In fact D720 had not been taking carbamazepine for around 16 months before arriving in Brook House. **D720's** self-reported diagnosis of type 2 diabetes and requirement for metformin was also not confirmed upon receipt of the community medical records. This kind of presentation, where the self-reported history is not appropriately corroborated by the community records, is relatively common in the secure setting. This means that healthcare providers need to ensure they have systems in place to check and confirm the medical history and medications to be prescribed where at all possible in order to attain an appropriate level of patient safety. In regard to medication, it is more often that people seek higher value medications than carbamazepine. Drugs such as opioids, gabapentin and benzodiazepines are highly sought-after and prescribers may be pressurised for these medications. D720 was appropriately referred to the mental health team and he was seen by the psychiatrist[131] who made a formal diagnosis of Bipolar

[131] As a GP, it falls outside of my expertise to comment on the assessment and management of a specialist. However, in my experience, the approach by Dr Belda in regard to the management of D720 is not uncommon in the prison setting.

Affective Disorder and Post-Traumatic Stress Disorder and commenced mood stabilising medication.

6.3.2.4. It is noted that Dr Belda makes a recommendation for D720 to receive *'trauma therapy in the community'* and this suggests that this particular intervention was unavailable in Brook House at this time.

6.3.3. Medication and prescription management

6.3.3.1. I have not at this stage been able to comprehensively assess the system for the provision of medication within Brook House, however, I did not find anything that gave cause for concern that the systems in place were inadequate. This is a preliminary view until such time that I receive further documentation allowing me to comment further on this aspect of the Inquiry.

6.3.3.2. The system for providing medication within the Immigration Removal setting will be based on a risk assessment of each detained **person's** factors and attempt to strike a balance between providing '**not** in-po**ssession**' (supervised) medication for safety and continuity reasons and '**in-possession**' medication with the emphasis on '**equivalence**' with the community where people would be largely expected to manage their own medication. It is important to note that the factors influencing whether or not a person is able to have their medication '**in-possession**' can be static or dynamic. As an example of a static factor, certain drugs will not ordinarily be made available owing to the risks associated with misuse and diversion, such as opioid medications, whilst non-contentious medications such as anti-hypertensives are often considered low risk. Dynamic factors, which need to be identified and acted upon by healthcare staff, include the status of a detained **person's** mental health and evidence of intent or acts to self-harm.

D1914

6.3.3.3. In the case of D1914 medication was being prescribed for his underlying heart condition. None of the medications that D1914 arrived with in Brook House would ordinarily be considered to be contentious in regard to allowing him to have these in-possession. These medications appear to have been appropriate and consistent with what I would have expected to see with regard to a patient with the underlying conditions he was known to have. It stands to reasons that the healthcare staff would have initially felt comfortable in providing D1914 with an in-possession supply of these medications having made a risk assessment (which is contained within the entry by Healthcare Assistant Katherine Wade on 29 March 2017) upon arrival in Brook House, the nature of the medications being considered and the desire to support the continuity of his treatment.

6.3.3.4. On 01 April 2017, Dr Chaudhary prescribed **D1914's** medication for his underlying heart condition and these were provided on a monthly (28 days) basis, which is what I would have expected to see. On 24 April 2017, these medications were then placed on repeat prescription by Dr Oozeerally and this is also in line with my expectations.

6.3.3.5. On 13 April 2017, Dr Oozeerally provided D1914 with a prescription of codeine for his chest pain symptoms and these were provided on a supervised basis. Codeine, being an opioid medication, is considered high-risk in terms of its liability to be diverted and/or misused. The prescription provided by Dr Oozeerally would have been available to have been administered by staff on a three-times daily basis at 08:30, 13:30 and 19:45. It is worth noting that the provision of supervised medication is highly labour intensive for healthcare staff. Many secure

establishments will only provide three-times-daily administration schedules and some prison establishments only provide twice-daily administration schedules.

6.3.3.6. On 15 May 2017, D1914 indicated that he would stop taking his regular medication if was "**not** taken **seriously**". On 24 May 2017, when attending to collect a further supply of his medication, it was noted that D1914 had been taking double the dose of aspirin which prompted a review by the GP the following day and a '**spot check**' by nurse Donna Batchelor on 25 May 2017 in order to establish the number of tablets in his possession in his room at that time. Whilst it appears there may have been some discrepancies between the numbers of tablets D1914 ought to have had in his possession, a pragmatic decision to continue to allow him to be responsible for his medication was agreed. In my view this was a proportionate and adequate response to this incident and indicates the attempt to weigh the risks and benefits of in-possession medication whilst preserving the autonomy of the detained person.

6.3.3.7. On 05 July 2017, D1914 made cuts to both arms and took an overdose of his in-possession medication. D1914 was taken to hospital and returned to Brook House the following day. On arrival an ACDT was commenced and he was placed on E wing for observation. Dr Chaudhary reverted **D1914's** medication from in-possession to not-in-possession on 07 July 2017 having taken into account the recent history of overdose and self-harm and placement on ACDT. In my view this was a proportionate and adequate response to this incident and indicates the clinical need to address the risks associated with **D1914's** recent episode of self-harm.

D720

6.3.3.8. On arrival in Brook House on 25 March 2017, D720 reported that he was prescribed medication for a number of significant underlying health conditions, including depression, type 2 diabetes mellitus and bipolar disorder. On this date. he stated to Dr Oozeerally that he was prescribed zopiclone, metformin and Tegretol. Dr Oozeerally explained that he needed **D720's** written consent to approach the community GP for access to their records in order to confirm the medical history and continue medications where appropriate. In my view, this is an adequate and appropriate course of action to take. This is both routine practice and is essential for confirming the information provided by D720 and are necessary steps for ensuring prescribing practices relevant for patient safety are in place. A fax was sent to the Queensbridge Group practice was sent the same day.

6.3.3.9. I have not been able to formally assess the operational process for the management of prescriptions and prescribed medication from the records provided or review in detail the relative quality of the management of prescriptions provided by the GPs within Brook House. This is a preliminary view until such time that I receive further documentation allowing me to comment further on this aspect of the Inquiry.

6.3.4. Clinical management of self-harm

6.3.4.1. In my view, the policies and procedures in place for the clinical management of self-harm appear to have been adequate.

6.3.4.2. I have reached this conclusion on the basis that there appear to be a number of documents in place, including:

- Violence Reduction Strategy[132]
- Suicide Prevention and Self-harm Management[133]
- Safeguarding Policy[134]
- Guidance for staff managing detainees on Constant Observations[135]
- Management of Adults at Risk in Immigration Detention[136]
- Introduction to Safer Custody, Gatwick IRC's Caring for Detainees at Risk[137]
- Enhanced Mental Health Training, Gatwick IRCs Caring for Detainees at Risk[138]
- E Wing Policy[139]
- Removal from Association (Rule 40) - Plus Annex B Initial Health Assessment and Care Map[140]
- Temporary Confinement (Rule 42)[141]

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[132] CJS000721 – **G4S Gatwick IRC's Violence Reduction Strategy, 19 August 2015**
[133] CJS006380 – G4S Gatwick IRCs Policy Document on Suicide Prevention & Self-Harm Management; reviewed date, September 2016
[134] CJS006379 – G4S Gatwick IRCs Safeguarding Policy, 09 May 2013
[135] CJS006378 – G4S Gatwick IRCs Guidance for staff managing detainees under constant supervision, May 2019
[136] CJS000731 – Home Office Detention Services Order 08/2016 on Management of Adults at Risk In Immigration Detention, February 2017 v1.0.
[137] CJS000052 – G4S Introduction to safer Custody, Gatwick IRC's Caring for detainees at Risk. Safer Community Team at Gatwick IRC's handbook, undated
[138] CJS000020 – Enhanced Mental Health Training, Gatwick IRCs Caring for Detainees at Risk
[139] CJS006043 – G4S E Wing Policy; last updated September 2018
[140] CJS006040 – G4S Draft Removal from Association, Safeguarding, undated
[141] CJS006041 – G4S Temporary Confinement, operational instructions, last reviewed September 2016 (DCF 3 Form not attached)

6.3.4.3. These policies adequately cover what I would have expected to see for use by staff in regard to the recognition and response to a detained person expressing active thoughts or plans to self-harm or following an act of self-harm. This includes the following of ACDT[142] process by both health and custodial staff. This is a preliminary view based on the material provided to date and until such time that I receive further evidence that assists in providing a perspective on the operational use of these policies and procedures. From the material provided to date, I have not been able to form a view on whether there was an adequate system in place for auditing this process and confirming compliance with their use or otherwise.

6.3.4.4. Within the case study for D1527, there was evidence of a system of handover between shifts of custodial staff which appeared to help to ensure that there was continuity of and awareness of risks of further episodes of self-harm. This is a preliminary view based on the material provided to date and until such time that I receive further evidence that assists in providing a perspective on the operational aspect of this handover. From the material provided to date, I have not been able to form a view on whether there was an adequate system in place for auditing this process and confirming compliance with its use or otherwise.

6.3.4.5. The use of Eden[143] wing provided custodial staff with an opportunity for the closer monitoring of individuals who had self-harmed, were expressing thoughts or plans

[142] CJS006380 – G4S Gatwick IRCs Policy Document on Suicide Prevention & Self-Harm Management; reviewed date, September 2016
[143] CJS006043 – G4S E Wing Policy; last updated September 2018

to self-harm or were recovering from the effects of illicit substances[144,145,146]. In relation to D1914, he was moved to E Wing in preparation for deportation the following day in view of concerns of staff that he would be likely to self-harm[147].

6.3.4.6. It is important to consider the reasons for a **person's** reasons and motivation for inflicting self-harm upon themselves. It is widely recognised that this can be an attempt to inflict a wound that would be life-threatening as a means to ending **one's** life. Classically, this would be associated with someone who is suffering a severe enduring mental health disorder, such as depression. However, it is important to consider that there may be a number of underlying reasons that people self-harm. It is recognised that this can be a mechanism for providing a '**release**' from underlying emotional distress. It is also recognised that self-harm can be as a result of a **person's** underlying frustration or feelings of hopelessness with being able to alter their situation leading to an '**escalation**' in their behaviour. This may seem to be extreme, but in my experience, this is all too common in the secure setting and is understandable from the perspective of the individual given the sense of powerlessness, loss of hope and/or frustration with '**the system**' and in the case of Brook House, the fear of being deported.

6.3.4.7. The policies and procedures in place appear to provide custodial and healthcare staff with the mechanisms by which to work together to share the responsibility for supporting an individual who may have self-harmed or be declaring their intent to do so. However, there are occasions where staff appear to lack sensitivity, or

[144] TRN0000095, pages 45-51 13 May 2017
[145] TRN0000095, pages 52-62 13 May 2017
[146] TRN0000095, pages 52-62 13 May 2017
[147] TRN0000014

empathy and are seen or heard to make uncaring remarks about the detained person. As I have set out previously, compassion fatigue and desensitisation are all too common in staff working in secure settings. This can be difficult to eradicate. Arrival of new staff members can be negatively influenced by the responses and behaviours of longer-standing members of staff which acts to '**normalise**' and make acceptable behaviours which would otherwise be unacceptable outside of the secure setting. I have not been provided with any evidence demonstrating a proactive approach to training in regard to addressing these issues which relate to the overall culture within the establishment.

6.3.5. Clinical management of food and fluid refusal

6.3.5.1. The Food and Fluid Policy[148] describes the management of suspected food and/or fluid refusal and incorporates responsibilities for both security and healthcare staff.

6.3.5.2. Whilst this policy does make reference to the NICE Guidance on 'self-harm', there is no apparent reference to other national guidance for clinical management for food and/or fluid refusal. I am aware of both the Department of Health Guidelines for the clinical management of people refusing food in immigration removal centres and prisons[149], January 2010 and Detention Services Order 03/2017 Care and management of detained individuals refusing food and/or fluid, September 2019[150].

6.3.5.3. Broadly speaking, the policies and procedures in place appeared to be reasonable and consistent with the expected approach to the identification of cases in which food and/or fluid refusal may be suspected or known to be taking place during the relevant period. On the basis of the evidence I have seen to date, there appeared to be adequate systems in place for ensuring continuity and handover of identified cases between security and healthcare teams and through the relevant working shift patterns. This is a preliminary view based on the

[148] CJS006084 – G4S Operational Instructions, Food & Fluid Policy, 01/09/2018 – NB the version provided to me is dated 2018
[149] I do not believe this remains in the public domain and I have not seen any update to this clinical guidance for the prison setting.
[150] Detention Services Order 03/2017 Care and management of detained individuals refusing food and/or fluid September 2019;
https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjbse7RkqD0AhVJecAKHXrhBSQQFnoECAgQAQ&url=https%3A%2F%2Fassets.publishing.service.gov.uk%2Fgovernment%2Fuploads%2Fsystem%2Fuploads%2Fattachment_data%2Ffile%2F958482%2FDSO_03_2017-management-of-detained-individuals-refusing-food-fluid.pdf&usg=AOvVaw3s_HyPpscrDEKmAN1wDm4q

material provided to date and until such time that I receive further evidence that assists in providing a perspective on the operational use of these policies and procedures. From the material provided to date, I have not been able to form a view on whether there was an adequate system in place for auditing these policies and procedures and confirming compliance with their use or otherwise.

6.3.5.4. In the case study of D1527, there were prolonged periods of apparent food refusal. Although I have not included the document references within the history set out above, there were numerous daily handover sheets completed. Healthcare staff were noted to record this information within the SystmOne clinical record and copies of the paper handover sheets were also scanned into the clinical record.

6.3.5.5. It is important to highlight the challenges of assessing and monitoring a person who is suspected to be on food and/or fluid refusal. Broadly speaking, there are two groups of individuals that can be defined:

- There are occasions where a detained person declares that they are going to stop eating and/or drinking on a voluntary basis as a form of protest (previously referred to a '**hunger strike**').

- There also individuals who stop eating and/or drinking on an involuntary basis, often as a result of an underlying mental or physical health condition. For example, this can be seen in people who have become acutely psychotic and are no longer able to care for themselves. Whilst this is

uncommon, it is clearly significant to identify at the earliest opportunity in order address and mitigate the effects of self-neglect. This latter group do not express any form of reason for their '**protest**' and may be non-verbal or incoherent.

6.3.5.6. In regard to the evidence I have been provided, I did not identify any individuals who fell into the latter category of '**involuntary**' food and/or fluid refusal.

6.3.5.7. In the case study of D1527, in my opinion this was a clear case of voluntary food and/or fluid refusal and was apparently in response to the issues with ongoing detention and prospect of deportation. Similarly, in the case of D1914, there was a brief period of voluntary food and/or fluid refusal as a result of his ongoing detention and prospect of deportation.

6.3.5.8. Even in a closed, secure environment such as Brook House, it can be extremely challenging to fully observe whether or not a person is taking in any nutrition and/or fluid. This is further complicated where rooms have internal sinks or food and drink can be purchased from the '**canteen**' above and beyond that which is provided by the **establishment's** servery at meal times. Equally, and for obvious reasons, it can be difficult to accurately account as to whether the person is continuing to pass adequate amounts of urine.

6.3.5.9. Assessing the overall nutritional and hydration status of an individual requires physical observation, including but not limited to pulse, blood pressure, weight and at an appropriate point, blood tests for biochemical analysis. This level of

assessment can only be undertaken where the detained person has given consent as it is not possible to force someone to cooperate if they do not wish to. These circumstances change only when a person has deemed to have lost capacity and in which case, healthcare staff are able to act in the **'best interest'** of the patient. It is usually the case that people who are on food and/or fluid refusal on an involuntary basis are more likely to lack capacity and this further physical assessment can be attempted where safe to do so. In the cases studies of D1527 and D1914, there was no suggestion that either detained person lacked capacity at any stage. In the case of food and/or fluid refusal, a **person's** capacity can be affected, but this tends to be in the advanced stages and take some time to become prevalent. In the case of D1527, from the evidence I have seen to date, it is my view that despite the lengthy periods of apparent food and/or fluid refusal, there did not appear to be any stage at which he lacked capacity, insofar as it is possible to form a view of capacity on that basis. As such D1527 was within his rights to refuse the physical observations which were offered on a daily basis by the healthcare staff during the period being examined.

6.3.6. Clinical management of Substance misuse treatment

6.3.6.1. The misuse of Psychoactive Substances (PS) appears to have been particularly prevalent within Brook House during the period being examined as evidenced by the video footage[151,152,153,154,155] and this would be considered in keeping with the experiences seen within the prison system. The consequences of PS misuse include a significant diversion of the attention of both custodial and healthcare staff who will be needed to support the intoxicated individual or individuals and for an unpredictable period of time. This impacts on the ability of staff to interact with the other detained persons and reliably attend to their normal planned duties and is relevant to both security and healthcare staff. As the video footage demonstrates, people under the influence are incapacitated for a significant period of time, may be vomiting and/or having seizure activity. This means they need to be monitored closely by healthcare staff for signs of deterioration in order to establish whether to intervene with life supporting measures such as cardio-pulmonary resuscitation (CPR) or whether an ambulance may be required. As there is no specific treatment or antidote for PS, often there is very little that healthcare staff can do other than offer supportive measures, such as placing the patient in the recovery position, clearing their airway, providing them with oxygen and reducing surrounding hazards whilst observing for deterioration.

6.3.6.2. In general terms, the supply and distribution of PS is considered to be an extension of organised criminal activity in the prison system, given its scale and

[151] KENCOV1043 – V2017070400007 – 04 July 2017: 00:20 - 19:15; 22:15-22:50, TRN0000033 pages 1-10
[152] TRN0000083 pages 3-12 19 June 2017
[153] TRN0000093 pages 9-14 15 June 2017
[154] TRN0000095, pages 52-62 13 May 2017
[155] TRN0000095, pages 45-51 13 May 2017

complexity. Illicit drugs entering secure and detained settings are likely to enter through a number of routes and will only be better addressed when appropriate levels of staff with the necessary equipment to detect and disrupt the supply chain are in place. In my view, it will not be possible to completely interrupt the supply of illicit substances and as there will continue to be demand for their effects, it is therefore highly likely there will continue to be disruptions as a consequence of acute intoxication.

6.3.6.3. Over the last year or so, the prison estate has been mobilising the use of x-ray scanners for the detection of internally concealed packages in newly arrived people in prison in order to better address the entry of illicit substances which have been concealed inside a body cavity for the purpose of use and/or dispersal within the prison. It is also known that psychoactive substances can be impregnated into the paper contained in letters and document being sent into prisons and there are means by which this has also been addressed. Depending on the nature of supply of illicit substances and whether or not these security measures could be provided for the Immigration Removal Centres, if they have not already, then these additional steps may help reduce the overall prevalence of individuals presenting as sedated and/or intoxicated.

6.3.6.4. Historically, substance misuse treatment is orientated toward the screening, assessment and treatment of dependence-forming drugs, primarily alcohol, opioid drugs (such as heroin) and benzodiazepines. Other illicit drugs including but not limited to cocaine, amphetamines, PS and cannabis do not have any specifically available medical intervention and therefore would normally

approached through psycho-social measures in order to reduce use and thereby minimise harm arising from their use where relevant.

6.3.6.5. The Gatwick IRC Drug and Alcohol strategy[156] sets out:

- *The Drug Strategy Team at Gatwick IRCs will work towards achieving the following aims.*
  - *Restricting the availability of illicit drugs and alcohol in our centres.*
  - *Identification of detainees who have been misusing drugs/alcohol.*
  - *Providing those detainees with advice, treatment and support of appropriate intensity.*
  - *Increasing the provision of alcohol treatment as resources allow.*
  - *Prevent mental and physical substance misuse related harm to detainees or others.*

6.3.6.6. Within Section 3, the strategy for preventing drugs from entering the Immigration Removal Centres is set out and includes ***'searching'***, ***'intelligence'***, ***'security'*** and ***'use of dogs'***. I have not been provided with any evidence describing the relative success of these measures in reducing the supply of illicit substances into Brook House during the relevant period.

6.3.6.7. What is clear from the video footage, is that there was a significant number of acutely intoxicated individuals despite these measures, suggesting that the measures in place are inadequate. The conclusion, in my view, is that the drug

[156] CJS006083 – Gatwick IRC's Drug and Alcohol Strategy 2017/2018

strategy would benefit from emboldening, primarily through additional resources, detection capabilities and staffing levels, as a minimum, in order to better address detection and otherwise help reduce PS use.

6.3.6.8. Within section 4.3, the strategy describes the aims for addressing the use of drugs and psychoactive substances:

- *Aim: To provide interventions and support to all detainees who have been identified as having substance misuse issues. That will be delivered in a flexible ways:*
    - *Information leaflets and posters to be displayed around the centre and for visitors.*
    - *One to one sessions with detainees*
    - *Room packs available for detainees*
    - *Training and support for staff*
    - *Implement a PS workshop that has been developed by Forward Trust*
    - *Work in partnership with all interested parties.*
- *Support and interventions can take form in packs, one to ones, and group work. We aim to utilise an NPS workshop that has been developed by Forward Trust for training of staff and detainees.*

6.3.6.9. This policy does provide a high-level approach to addressing the longer terms needs of people who may be misusing illicit substances and how support can be offered to those who require assistance with harm reduction. However, it does not set out the clinical protocol necessary for addressing the needs of a person who is acutely intoxicated or otherwise under the influence of PS.

6.3.6.10. Video footage[157,158,159160,161,162,163] demonstrates staff attending to detainees on a number of occasions and in some cases possibly to the same individual on different days. On the whole, the healthcare staff appear to respond promptly to the request from custodial staff for their assistance and engage in their assessment of the detained person without delay. Where the footage allows, healthcare staff are seen checking vital signs, such as pulse, blood pressure, peripheral oxygen saturations and pupillary reaction to light in most cases.

6.3.6.11. In general terms, the approach by the healthcare staff was attentive and appeared to be clinically appropriate whilst remaining largely sympathetic to the needs of the intoxicated individual. However, on occasion, healthcare staff were observed to be somewhat sarcastic or mocking in their tone when speaking to the detained person. That said, it was more often the case that within the video footage, it was the custodial staff who were more open in their mocking of the intoxicated individual. It is difficult to conclude whether the healthcare staff were adopting their mocking approach as a result of their own frustration, desensitisation or compassion fatigue in having to deal with the intoxicated individuals, and/or whether there was some influence as a result of the custodial staff's behaviour.

[157] TRN0000095, pages 45-51, 13 May 2017
[158] TRN0000095, pages 52-62 13 May 2017
[159] TRN0000095, pages 63-64 13 May 2017
[160] TRN000001514 June 2017
[161] TRN0000093 pages 9-14 15 June 2017
[162] TRN0000093 pages 15-2115 June 2017
[163] TRN0000083 pages 3-12 19 June 2017

6.3.6.12. In summary, the clinical impact of dealing with high numbers of detained persons who are under the influence of illicit substances has a significant impact on the overall ability of the healthcare team to deliver the service that they were commissioned to provide as qualified staff are repeatedly diverted to the acute needs of intoxicated individuals. Whilst the staff are generally trained to be able to deal with emergencies, the healthcare services in Immigration Removal Centres were not commissioned specifically to deal with the scale and severity of these issues.

6.3.6.13. In my view, the healthcare staff appeared to respond adequately to the acute needs of the detained persons who were apparently under the influence of psychoactive substances.

6.3.6.14. I have not been provided with any records of cases that involved the more typical aspects I would expect to see in line with a substance misuse service, such as alcohol detoxification or opioid substitution therapy prescribing and so I am unable to comment further until I receive further documentation.

6.4. Regarding the extent to which the mental health issues or needs of detainees played, or may have played, a part in the treatment to which those detainees were subjected:

6.4.1. There is a spectrum of what is considered to be a mental health issue versus behavioural traits, and these may overlap. In addition, people may adopt different coping strategies, including the use of illicit substances and self-harm, including food and/or fluid refusal.

6.4.2. The mental health service provision was intended to serve the needs of those who may have or who may develop acute severe mental health issues, such us severe depression, post-traumatic stress disorder, bipolar disorder or acute psychosis. By default, the milder end of the spectrum of mental health issues, including for example, anxiety and depression would be addressed by the primary care GPs.

6.4.3. There is a significant population within the secure and detained settings who fall in between these two ends of the primary and secondary-care spectrum and for whom no service has been specifically commissioned. These may be people with persistent substance misuse issues, aberrant coping strategies resulting in aggression or violence towards themselves and/or others, manipulative behaviours affecting staff (custodial and/or health) including food and/or fluid refusal, defiance when instructed etc. Frequently, these behaviours will be labelled as '**personality disorders**' for which, to my knowledge, there is no immediately accessible treatment within the Immigration Removal estate[164]. This group of patients is often considered to be challenging to

[164] I am aware of a number of therapeutic communities within the prison estate and I believe there are others that will accept people from prison.

work with and can be mentally and emotionally tiring for both custodial and healthcare staff. In the case studies, it is clear that some of the detained persons had a well-known past history of offending behaviour and it appears that this may lead to prejudice by staff, labelling them as violent and/or aggressive. These behaviours are well-recognised within the criminal justice system within the UK and a significant proportion of the detained persons being brought to Brook House during the period being examined were arrivals from the prison estate having served sentences for their offences.

6.4.4. I have not been provided with any evidence that detained persons had access to psychological therapies which could be helpful for dealing with the high levels of past trauma that appears to be prevalent within the population within Brook House.

6.4.5. There are significant challenges for both custodial and healthcare staff in attempting to address the complex needs of the population in Brook House. Ideally, they would benefit from:

- The skills and training to discriminate between the different types of behaviour I have described above and how to appropriately respond when presented with adverse behaviours, in particular de-escalation
- The skills and training to avoid becoming desensitised when faced with repeated and sustained challenging behaviour
- Adequate staffing levels with the appropriate skill-mix necessary for dealing with different types of scenario

6.4.6. Detained persons in the context of Immigration Removal will, in many cases, have little or any reasonable level of control over their circumstances. It is understandable, from a human perspective, when faced with ongoing, apparently unlimited detention, in the physical environment consistent with that of a prison and in the absence of having been convicted of an offence, that detained persons are, in some cases, at significant risk of loss of hope and feeling of powerlessness over their situation. The sense of loss of hope interacts with mental health and coping strategies. In some cases there may be increased anxiety and/or depressed mood and this may also manifest in escalating behaviours in an attempt to gain some form of control over their circumstances. For example, within the case study of D1527, heightened agitation, can be seen[165][166] with the detained person who appears to be trying to raise awareness for their particular problem and frustration. D1914 is often noted to be abusive towards healthcare staff when his expectations are not met. Equally, other adverse coping strategies, such as the use of illicit substances to cope with boredom and/or unpleasant emotions can often aggravate these underlying factors and lead to a compound effect.

6.4.7. The effect on healthcare staff of working continuously in this volatile and high-pressure environment can result in desensitisation and '**normalising**' of maladaptive coping strategies. It is possible to extrapolate the link between the inability of the staff to de-escalate different situations and the increased potential for Use of Force. I have not been provided with the overall number of episodes of Use of Force within Brook or been able to consider these relative to the Immigration Removal estate. The case

[165] BBC000091 – KENCOV1012 – V2017050400021 – 04 May 2017: 17:45-29:59, TRN0000004
[166] BBC000091 – KENCOV1012 – V2017050400022 – 04 May 2017: 00:00-09:09, TRN0000006

of D1527 included video footage[167] on 25 April 2017 where an excessive Use of Force was used but not recorded following the incident. The case of D687 included video footage[168][169] on 13 May 2017 where Use of Force was applied in order to remove a ligature.

6.4.8. In my opinion, during the period in question there appears to have been a mixture of inadequately trained healthcare and custodial staff who were tasked with dealing with a number of considerably complex detained persons which lead to a prevailing negative culture in Brook House.

[167] BBC000071 – KENCOV1007 – V2017042500021 – 25 April 2017 [00:00-27:49], TRN0000002
[168] BBC000070 – KENCOV1016 – V2017051300011 02:05 – 30:00 , TRN0000095 (pages 33-39)
[169] BBC000070 – KENCOV1016 – V2017051300012 00:00 – 02:24, TRN0000095 (pages 41-42)

6.5. Regarding the identification of areas for improvement of practices, policies, procedures, oversight, and systems (of the Home Office and its contractors) that could be put in place in future to identify and act upon any identified shortcomings:

6.5.1. Practices

Use of force

6.5.2. Based on the documentary evidence provided to date, a more robust approach to the system of education and training is required for both custodial and healthcare staff. Ideally, some of the training provided should involve the opportunity to train both custodial and healthcare staff alongside one another. This will help to ensure a cooperative and collaborative approach is developed between the two elements who owe a '**duty** of **care**' to detained persons within Brook House and a better understanding of each **other's** roles and responsibilities. By ensuring that healthcare staff have a better understanding of their role in regard to '**professional independence**', the recognition of any poor practices or ill-treatment by custodial staff could be improved.

ACDT

6.5.3. This would be particularly relevant in regard to Use of Force and Control and Restraint as well as self-harm and the ACDT process. Ideally these mechanisms should be considered as a last resort and as such improved training would aim to provide staff with the improved skills and understanding necessary for the earlier detection and intervention with the aim of reducing the need for crisis management where possible.

Trauma-informed Care

6.5.4. 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.

Psychoactive Substances and Substance misuse

6.5.5. In the event that the use of psychoactive substances remains an issue within Brook House, learning from the measures that have been put in place within the prison estate may be beneficial for reducing the overall prevalence of incidents relating to the use of these drugs.

Rule 35

6.5.6. 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.

6.5.7. The process for sharing of information between stakeholders in relation to the Rule 35 process appears to be reliant on '**paper**' systems which contributes 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.

6.5.8. Policies and procedures

6.5.9. The suite of healthcare policies that I have been provided with in place during the relevant period appeared to be relatively basic and I was not able to identify the 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.

6.5.10. 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 and use of both extant and new policies. It is essential that new staff are provided with an appropriate period of induction in order to be familiar with the relevant polices and procedures in place.

6.5.11. Overall oversight and systems

6.5.12. The use of detention prior to deportation is a complex area. Whilst I am not an expert in this area, it is apparent that some of the issues that arose in Brook House during the period in question were exacerbated by prolonged or indeterminate periods of detention before deportation. I accept that setting specific time frames for length of detention would not prevent issues these from arising. In my view a comprehensive review of the use of detention would be beneficial and ideally, this would incorporate a review of the Rule 35 (1), Rule 35 (2) and Rule 35 (3) and Adults at Risk policy.

6.5.13. The systems in place during the relevant period were apparently lacking in any systematic process for feedback, quality assurance and quality improvement activity.

Without these mechanisms in place, any system going forwards will encounter similar issues relating to overall adequacy and fitness for purpose.

6.5.14. The systematic gathering and reporting of data relevant for understanding the issues and priorities of the population within Brook House does not appear to have been in place during the relevant period. An appropriate forum for the presentation and understanding of available data involving relevant stakeholders, including but not limited to custodial, healthcare and Home Office staff would be necessary for helping to address presenting issues and identifying trends. Without these systems in place, inadequacies in the system may not be proactively highlighted and fed back accordingly and opportunities to address them may be missed.

6.5.15. <u>Other areas for consideration</u>

6.5.16. The system in place during for the use of Rule 35 and the Adults at Risk policy appears to be flawed. As I have set out above, the GPs tasked with the responsibility for providing the Rule 35 (3) reports are unlikely to be trained and skilled to the level of expertise in some of the aspects of the report apparently required for this process. There is also the important additional issue that the GP may be conflicted in providing a Rule 35 (3) report and is not sufficiently independent within this process. I note that there also appears to be a lack of medical expertise within the Home Office for the use and interpretation of the information provided by the GPs within the Rule 35 (3) reports. In my view, a system for providing the support of a number of independent medical advisors within the Home Office would be beneficial. This approach could also be helpful in gathering information and advising the Home Office on cases being

considered prior to detention allowing for the use of this to be avoided for the more medically high-risk cases.

6.5.17. External to Brook House

6.5.18. The development of a clinical network for Immigration Removal Centres would be beneficial for sharing best practice and knowledge. This would need to be appropriately resourced to ensure uptake and attendance.

6.5.19. Inside Brook House

6.5.20. Ensuring that sufficient time and resource was committed for the learning and development of both custodial and healthcare staff is essential for developing and maintaining a positive culture.

7. Statement of Truth

- I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

  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 in its truth.

Signed: **Signature**

Dated: 18 November 2021

Appendix 1

Experience and qualifications

Dr Hard qualified as a GP and has over 15 years 'experience within the UK prison healthcare system and holds a number of complementary roles and responsibilities over and above clinical practice. Dr Hard was awarded a Fellowship by the Royal College of GPs for his achievements in the development of prison healthcare.

Dr Hard is the current Chair of the Royal College of GPs Secure Environments Group and has held this role for 5 years. Within this he is responsible for organising the annual Health & Justice Summit - the keynote event for partners and stakeholders working and commissioning in this arena.

Dr Hard has over ten **years'** experience as an Expert Witness experience with primary expertise in regard to care being provided in the prison setting. As an Expert he has provided over 450 reports, largely relating to clinical negligence and has appeared in court approximately ten times. Dr Hard has provided his expertise for Coroner's Inquests and in cases where the NHS Resolution, Crown Prosecution Service, General Medical Council and Medical Defence Organisations require specialist advice. Dr Hard is an Associate Clinical Advisor to the Parliamentary and Health Service Ombudsman and provides advice on cases involving prison care. Dr Hard has been commissioned as an independent Clinical Reviewer to assist the Prison and Probation Ombudsman investigating Deaths in Custody and has assisted in the investigation of over 15 deaths, including one Level 3 review and one homicide.

Dr Hard is the Clinical Lead for the Health & Justice Information System (for NHS England & NHS Improvement) - the development of the NHS Spine enablement for prison clinical records.

Dr Hard was commissioned by the FCO to visit and report on the Prison system in the Cayman Islands in late 2019 with a specific focus on mental health.

Dr Hard contributed as an Expert to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on a visit to the prisons and police custody suites in Greece in early 2019 and then to prisons and police custody suites in Serbia in 2021.

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EDUCATION

Schools	The Haverford School, Pennsylvania, USA	1980 - 1984
	Barker College, Waitara, Sydney, Australia	1984 - 1985
	Whitgift School, South Croydon, UK	1985 - 1988
	Cambridge Tutors College, Croydon, UK	1988 - 1989
Undergraduate	University College London MBBS (London)	1990 - 1998
Awards	Prankerd Jones Memorial Prize For 'The Significance of Digital Amputation to the Patient'	1993
	Amulree-Slater Bursary	1996
	British Medical and Dental Student's Trust Award	1996
Postgraduate	Certificate of Completion of Training in General Practice	2006
	Membership of the RCGP	2006
	RCGP Substance Misuse Part I, Part II and Secure Environments module	2007
	RCGP Healthcare for Healthcare Professionals Part 1	2011
	RCGP Healthcare for Healthcare Professionals Part 2	2012
	Fellowship of the Royal College of GPs	2014
	Cardiff University Law School Bond Solon Expert Witness Certificate	2015
	Member of the Expert Witness Institute	2015
	Bond Solon Masterclass in Report Writing	2016
Appraisal		March 2020
Revalidation		July 2018
Medical Performers Lists:		Welsh and English

PUBLICATIONS

Equivalence, Justice, Injustice – Health and Social Care Decision Making in Relation to Prison Populations [Link]	2021
Early vaccination of prisoners and prison staff is important to reduce mortality and protect the rights of prisoners [Link]	2021
Remote consultations in prison mental healthcare in England: impacts of COVID-19 [Link] BJ Psych Open	2021
High COVID-19 death rates in prisons in England and Wales, and the need for early vaccination [Link], The Lancet Respiratory Medicine	2021
OUD Care Service Improvement with Prolonged-release Buprenorphine in Prisons: Cost Estimation Analysis [Link]	2020
COVID-19: digital equivalence of health care in English prisons [Link]	2020
The Effects of COVID-19 on Self-harm in UK Prisons [Link] [Link]	2020
Effects of the COVID-19 pandemic on the mental health of prisoners [Link]	2020
Secondary care clinicians and staff have a key role in delivering equivalence of care for prisoners: A qualitative study of prisoners 'experiences [Link]	2020
Medicine in secure environments, MDU Journal - Dr Jake Hard Dr Caroline Fryar	2019
Equivalence of care in Secure Environments in the UK, RCGP Position statement [Link]	2018

PRESENT POSTS

Chief Medical Officer	Correct Care UK	2021 - present
Clinical Director	HMP Cardiff	2021 - present
Chief Medical Officer (Interim)	Prenetics EMEA	2020 - present
Clinical Lead	Health & Justice Information Service, NHS England	2013 - present
Co-deputy Director	Health for Health Professionals Wales	2012 - present
Expert Witness		2011 - present

PRESENT NON-CLINICAL POSTS

Chair	RCGP Secure Environments Group	2016 - present
Responsible Officer	Medteam Healthcare Ltd	2012 - present

PAST NON-CLINICAL POSTS

Chair	RCGP Wales Secure Environments Network	2008 - 2017
Vice-Chair	RCGP Secure Environments Group	2010 - 2013
Honorary Treasurer	RCGP South East Wales Faculty	2008 - 2013
Member	NICE Guideline Development Group [NG57]: Physical Health of People in Prison	2014 - 2016

CLINICAL EXPERIENCE - Current Posts

Chief Medical Officer for Correct Care UK 2021 – Ongoing

Clinical Lead for the Health and Justice Information Service 2013 - Ongoing

The project is being delivered by NHS Digital, North East London Commissioning Support Unit with NHS England and will provide the second generation IT system to be delivered into the prison environments and will also include the police custody and other settings. The role involves holding meetings with relevant stakeholders and assisting the project team with strategic advice.

Expert Witness 2011 - Ongoing

Portfolio of work providing expert reports on Breach of Duty, Condition & Prognosis and other medical reports in Civil claims. I provided advice to the GMC, Medical Defence Organisations and NHS Resolution via a wide variety of solicitors. I am also an Associate advisor to the Parliamentary and Health Service Ombudsman.

Health for Health Professionals Wales - Co-deputy Director 2012 - Ongoing

I have been involved with this service since inception in 2012. It was originally designed to provide access to CBT for doctors living and working in Wales. In response to COVID-19, additional funding from Welsh Government has expanded the service to provide sign-posting to a tiered model of support for all NHS workers in Wales.

PREVIOUS CLINICAL EXPERIENCE

GP On-call cover at Ysbyty'r Seren Field Hospital
I assisted the Director for Primary Care within Cwm Taf Morgannwg University Health Board with the implementation and opening of a 240 bed Field Hospital as part of the ongoing COVID-19 pandemic response.

Medical Director (Prisons) CRG Medical Services 2019 - 2021

GP On-call Cover Abergarw Manor Field Hospital April – August 2020
Provision of on-call overnight and weekend cover for a temporary COVID-19 Field Hospital for EMI and Care of the Elderly patients

Civilian Medical Practitioner 2014 - 2020
Civilian Medical Practitioner in Hereford providing care to the UK Special Forces.

Prison GP - HMP Eastwood Park and HMP Leyhill 2015 - 2020
GP in HMP Eastwood Park serving approximately 360 women prisoners and the mother and baby unit. This includes general practice clinics, new reception and substance misuse. Leyhill Prison is a Category D 'open 'prison serving approximately 530 men. This includes some on-call and and weekend cover.

GP with Special Interest in Substance Misuse - CDAT Abertawe Bromorgannwg UHB 2008 - 2016
Provide an average of 3 sessions per week as the 'virtual 'GP. Predominantly looking after patients on opiate replacement therapy and on medication following detoxification from alcohol. I will also see a mix of cases for assessment when coming into treatment to support the 'core 'team. I am responsible for supervising the two nurse-prescribers.

Prison GP - HMP Swansea 2012 - 2014
Weekly commitment of 1 day per week providing GP clinics in Cat B male Local Prison, capacity of ~450. Clinics cover both new admissions and the assessment of those in acute withdrawal as well as routine general physical health problems.

GP Principal - Ynysangharad Surgery, Pontypridd 2013 - 2014
Part-time Partner (6 sessions) in Pontypridd, South Wales.

Out of Hours GP 2006 - 2013
Undertake ad-hoc face-to-face, mobile and triage shifts in several localities across South Wales.

Partner GP - St Johns Medical Practice, Aberdare 2009 - 2011
Initially joined the practice as a salaried GP at the point of taking the practice from managed status to Independent contractor status. Helped develop several enhanced services within the practice providing care for local surgeries including substance misuse, dermatology/minor surgery. Solely responsible for developing and leading the GPwSI ENT service within the Cwm Taf LHB area which is the first of its kind in Wales.

Prison GP & Clinical Lead - HMP & YOI Parc, Bridgend 2006 - 2011
Clinical lead for a team of 6 GPs working within a team of nursing staff (RMN and RGN) providing a range of healthcare clinics to a Category B private (G4S) male prison housing around 1500 inmates. There is provision for young offenders, adolescent and juvenile inmates. Four sessions per week comprising 'Segregation round', GP clinics, new admissions, minor operations, in-patients and any emergencies. Central role in leading the team of GPs through the process of moving healthcare into new accommodation, the increased population with prison expansion and the rolling out of SystemOne computer-based clinical records. Provision of on-call services.

Substance Misuse GP (One session) - Kaleidoscope Project, Newport 2009 - 2011
Substitute opiate prescribing to clients in a Methadone dispensing programme.

GP with Special Interest in Substance Misuse Substance Misuse - Drugaid Drug Rehabilitation Requirement, Cwm Taf 2007 - 2012
Substitute opiate prescribing to clients involved with the Probation services in Merthyr Tydfil and Pontypridd.

Salaried GP - Nantgarw Road Surgery, Caerphilly 2008 - 2009
Locum GP - Taffs Well Medical Centre, Taffs Well 2006 - 2007

Locum Prison GP - HMP Leicester 2006 - 2007
Worked within team of nurses and assistants providing a wide range of primary care for over 300 male inmates in a category B remand prison.

GP Training		2004 - 2006
GP Registrar (GP VTS: 4th of 4 posts)	Taff Vale Surgery, Pontypridd	
Psychiatry SHO (GP VTS: 3rd of 4 posts)	Whitchurch Hospital, Cardiff	
GP Registrar (GP VTS: 2nd of 4 posts)	Foundry Town Clinic, Aberdare	
Paediatric SHO (GP VTS: 1st of 4 posts)	Royal Glamorgan Hospital, Llantrisant	

Locum positions (Summary)		2001 - 2004
Locum Burns & Plastics SHO	Morriston Hospital, Swansea	
Locum CMP MOD	RTMC, Chetwynd Barracks, Chilwell	
Locum ENT SHO	Royal Free Hospital, London	
Trust Cardio-thoracic SHO	John Radcliffe Hospital, Oxford	

Basic Surgical Training		1999 - 2001
Plastic Surgery SHO (Surgical Rotation)	The Queen Victoria Hospital, East Grinstead	

ENT SHO (Surgical Rotation)	Kent & Sussex Hospital, Tunbridge Wells	
Trauma/Ortho SHO (Surgical Rotation)	Kent & Sussex Hospital, Tunbridge Wells	
General Surgery SHO (Surgical Rotation)	Maidstone General Hospital, Maidstone	
A & E SHO	Joyce Green Hospital, Dartford	1999 - 1999
Medicine & Surgery Pre-registration	Chase Farm Hospital, Enfield	1998 - 1999

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Appendix 2

List of background material reviewed for the case

1. **The BBC Panorama programme *"Under-Cover: Britain's Immigration Secrets"*, aired on 4 September 2017.**

   [https://youtu.be/_fp0QLDKgME]

2. **Detention Centre Rules 2001: Rules 34, 45, 40 and 42 are particularly relevant.**

   [https://www.legislation.gov.uk/uksi/2001/238/contents]

3. **Verita report of its independent investigation into concerns about Brook House IRC (redacted).**

   [https://www.verita.net/wp-content/uploads/2018/12/G4S-version-report.pdf]

4. **Her Majesty's Inspectorate of Prisons report March 2017.**

   [https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/brook-houseimmigration-removal-centre/]

5. **Stephen Shaw report of July 2018: Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons.**

   [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728376/Shaw_report_2018_Final_web_accessible.pdf.]

6. **Home Affairs Select Committee Report on Immigration Detention March 2019.**

   [https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/913/913.pdf]

Appendix 3

Documents

Reference	Title
CJS000731	Home Office Detention Services Order 08/2016 on Management of Adults at Risk In Immigration Detention, February 2017 v1.0
CJS000224	PowerPoint presentation on Immigration Detention and Healthcare Issued by Chrissie Williams, Senior Nurse G4S Health. Slides mostly irrelevant, about various illnesses, but slide 22 references use of control and restraint techniques, undated.
CJS000360	G4S Use of Force policy document, March 2016
CJS000425	UKBA Document 'Commercial in Confidence' section titled '19 Staffing', with Staffing Proposals, Tables with Staff on duty figures, and the different positions of staff at Brook House, undated
CJS000507	G4S Gatwick IRCs Supported Living Plan Policy 01, version 2.0, amended 11 May 2017 to include new DSO Adults at Risk
CJS000527	G4S Health Quality Committee Meeting Minutes at Brook House IRC, 31 October 2017
CJS000589	G4S Healthcare Meeting of Gatwick IRC, PDA and Borders: Quality Committee Meeting Agenda, 29 January 2018
CJS000706	G4S Custodial & Detentions Services Incident Reporting Procedures, v2, 03 July 2016
CJS000733	G4S Gatwick IRC's Drug and Alcohol Strategy for October 2017/2018 aiming to support detainees to live a substance misuse free lifestyle, undated
CJS004200	Timetable of staff cover, dated 10 June 2017
CJS004273	G4S Policing Support and Healthcare Service: Contract Level Clinical Governance (Meeting minutes), 15 January 2018
CJS004274	G4S Policing Support and Healthcare Service: Contract Level Clinical Governance (Meeting minutes), 18 December 2017
CJS004281	G4S Policing Support and Healthcare Service: Contract Level Clinical Governance (Meeting minutes), 20 November 2017

Reference	Title
CJS004282	G4S Health Service - Senior Nurse Meeting, 12 January 2018
CJS004283	G4S Contract Level Clinical Governance (Healthcare) - Meeting Minutes, 21 February 2018
HOM002511	DSO 06/2008 Assessment Care in Detention and Teamwork (ACDT) document v2.0, issued 18/07/2008
HOM003967	G4S – Safeguarding Policy document; undated
VER000195	82 – Detainee focus group original notes – Copy
VER000196	80 – Detainee focus group 1 notes KL – Copy
VER000202	81 – Detainee focus group 2 notes – Copy
VER000204	83 – Detainee focus group 1 notes – Copy
CJS007047	G4S monitoring of patients during and after restraint 01/08/2016
CJS007048	G4S managing patients during and after restraint in a secure environment, 01/06/2019
CJS007080	G4S safeguarding policy and procedures 01/09/2019
CJS007035	Record of R35 training for Dr Oozeerally on 18.01.17 31/01/2017
HOM002591	Home Office guidance on Detention Centre Rule 35 (DSO 09/2016), v4.0, published 06/12/2016
CJS006040	G4S Draft Removal from Association, Safeguarding, undated
CJS006041	G4S Temporary Confinement, operational instructions, last reviewed September 2016
CJS006043	G4S E Wing Policy; last updated September 2018
CJS006045	G4S Detainee Reception & Departures, Brook House Policies, last reviewed 4 May 2016
CJS006046	Detainee Admissions & Departures Brook House IRC, operational instructions; Version 3; 05/02/2014
CJS006083	Gatwick IRC's Drug and Alcohol Strategy 2017/2018
CJS006084	G4S Operational Instructions, Food & Fluid Policy, 01/09/2018

Reference	Title
CJS006378	G4S Gatwick IRCs Guidance for staff managing detainees under constant supervision, May 2019
CJS006379	G4S Gatwick IRCs Safeguarding Policy, 09 May 2013
CJS006380	G4S Gatwick IRCs Policy Document on Suicide Prevention & Self-Harm Management; reviewed date, September 2016
CJS006391	G4S Justice Health Gatwick IRCs Welcome Pack, undated
CJS000020	G4S, Enhanced Mental Health Training slides - Gatwick IRC's, undated
CJS000052	G4S Introduction to safer Custody, Gatwick IRC's Caring for detainees at Risk. Safer Community Team at Gatwick IRC's handbook, undated
CJS000721	G4S Gatwick IRC's Violence Reduction Strategy, 19 August 2015
	Other
HOM002581	Detention Centre Rule 35 slides for GP Training, dated 10/2015
HOM002579	Email exchange between Helen Wilkinson, PSU Home Office, and Sophia Anderson, NRC Home Office

Appendix 4

Blank Annex A: Rule 35 (1) report

Detention services order 9/2016 - Detention centre rule 35

Rule 35(1) report - a detainee whose health is likely to be injuriously affected by continued detention or the conditions of detention

Annex A: Rule 35(1) report

Detention services order 9/2016 – Detention centre rule 35

Rule 35(1) report – a detainee whose health is likely to be injuriously affected by continued detention or the conditions of detention

Section 1: Detainee's details

Forename(s):	
Surname:	
Date of Birth:	
Home Office reference number	
Immigration Removal Centre:	

Section 2: Detainee's authority to release medical information

The detainee named above has authorised the release of the medical information in this report in line with the guidance in DSO 1/2016 – The Protection, Use and Sharing of Medical Information Relating to People Detained Under Immigration Powers.

Section 3: Medical practitioner's report
(Please read the notes at the end of this form)

I write in respect of the detainee named above in my capacity as an immigration removal centre medical practitioner. I hereby report that this detainee's health is likely to be injuriously affected by continued detention or the conditions of detention.

Section 4: Relevant clinical information

i) Why is the detainee's physical and/or mental health likely to be injuriously affected by continued detention or the conditions of detention? Please include as much detail as possible to aid in the consideration of this report. This must include an outline of the detainee's relevant physical and/or mental health condition(s).

ii) What treatment is the detainee receiving? Is specialist input being provided, either within the IRC or as a hospital outpatient or inpatient?

iii) In the case of mental health problems, has there been a detailed mental health assessment and, if so, carried out by whom and with what result/recommendation? If not, is an assessment scheduled to take place and, if so, when? Please attach the report of any assessment or give a brief overview.

Section 5: Assessment

i) What impact is detention or the conditions of detention having (or likely to have) on the detainee's health and why?

ii) Can remedial action be taken to minimise the risks to the detainee's health whilst in detention? If so, what action and in what timeframe?

iii) If the risks to the detainee's health are not yet serious, are they assessed as likely to become so in a particular timeframe (ie in a matter of days or weeks, or only if detention continued for an appreciably longer period)?

iv) How would release from detention affect the detainee's health? What alternative care and/or treatment might be available in the community that is not available in detention?

v) Are there any special considerations that need to be taken into account if the detainee were to be released? Can the detainee travel independently to a release address?

Other comments:

Section 6: Signature

Signed:.....

Printed name:.....

Position and qualifications:
.....

Date.....

If other healthcare professionals have supported you in examining the detainee and/or in producing this report their details must be given below:

Signed:.....

Printed name:.....

Position and qualifications:
.....

Date.....

Signed:.....

Printed name:.....

Position and qualifications:
.....

Date.....

Signed:.....

Printed name:.....

Position and qualifications:
.....

Date.....

Notes – for the medical practitioner

Your report must be completed legibly, with all questions being completed fully. Consideration of the report will be delayed if Home Office officials have to return the report to seek clarification.

If the Home Office requests clarification of any point in this report, this must be provided promptly.

Once completed this report must be faxed to the Home Office IRC Team.

A signed copy of this report must be placed on the detainee's medical record and another signed copy provided to the detainee free of charge.

The Home Office response must on receipt be reviewed by the medical practitioner. If it is considered to unsatisfactorily address the original concerns, it must be escalated to the Home Office IRC Team.

Notes – for the Home Office caseworker

You must consider and respond to this report in line with the guidance and instructions in:

- **Chapter 55b Immigration removals, enforcement and detention: general instructions – Adults at risk in immigration detention**
- **Detention services order (DSO) 9/2016 – Detention centre rule 35**

Appendix 5

Blank Rule 35 (3) Annex

Detention services order 9/2016 - Detention centre rule 35

Rule 35(3) report - concerns that a detainee may have been a victim of torture

Annex C: Rule 35(3) report

Detention services order 9/2016 – Detention centre rule 35

Rule 35(3) report – concerns that a detainee may have been a victim of torture

Section 1: Detainee's details

Forename(s):	
Surname:	
Date of Birth:	
Home Office reference number	
Immigration Removal Centre:	

Section 2: Detainee's authority to release medical information

The detainee named above has authorised the release of the medical information in this report in line with the guidance in DSO 1/2016 – The Protection, Use and Sharing of Medical Information Relating to People Detained Under Immigration Powers.

Section 3: Medical practitioner's report
(Please read the notes at the end of this form)

I have examined the detainee named above in my capacity as an immigration removal centre medical practitioner and hereby report that I have concerns that the detainee may have been a victim of torture. This is a factual report rather than a medico-legal one.

I understand that torture in this context means:

> Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind.

Section 4: Detainee's account

Please provide details of the account given to you by the detainee of the alleged torture. In particular, please provide:

- as much detail as possible about the detainee's explanation for the cause of each injury, scar or symptom (physical or psychological)
- details of **when**, **where**, **how**, **over what timeframe** and **why** the torture is said to have happened, if possible

Section 5: Relevant clinical observations and findings

Please provide details of your objective clinical observations and findings. This should include:

- details of all scarring or other physical marks, psychological symptoms, physical disability or impairment
- details of any medical or professional treatment or support that the detainee has received (including outside the UK) or is receiving and from whom
- any information in respect of previous or current physical or mental health problems which may be a result of having been tortured

Section 6: Assessment

Please set out your reasoned assessment of why, on the basis of the detainee's account together with your own examination and clinical findings, you are concerned that the detainee may have been a victim of torture. This should include your assessment of:

- the consistency of any physical (eg scars) and/or psychological findings with the detainee's allegations, including any evidence to the contrary
- whether there might be other plausible causes for the findings
- the impact **detention** is having on the detainee and why, including the likely impact of ongoing detention

If there are no physical or psychological findings to support the detainee's account, you **must** state why, in your professional assessment, you nevertheless have objective grounds for your concern.

Section 7: Signature

Signed:.....

Printed name:.....

Position and qualifications:
.....

Date.....

If other healthcare professionals have supported you in examining the detainee and/or in producing this report their details must be given below:

Signed:.....

Printed name:.....

Position and qualifications:
.....

Date.....

Signed:.....

Printed name:.....

Position and qualifications:
.....

Date.....

Signed:.....

Printed name:.....

Position and qualifications:
.....

Date.....

Notes – for the medical practitioner

The requirement to report need only be triggered by you having a concern that the detainee may have been a victim of torture. However, you should not make a report where the detainee's experience of harm or mistreatment does not meet the definition of torture given in section 3 above, or where you do not have clinical concerns that the detainee may have been a victim of torture, including instances where there is no basis for concern other than an unsupported claim by the detainee to have been a victim of torture. If, however, you do have concerns that the detainee may nevertheless be particularly vulnerable to harm in detention you must report those concerns, by completion of a Rule 35(1) report, if appropriate, an IS91 RA Part C (risk assessment), or by passing the information direct to the Home Office Immigration Enforcement team at the centre.

Your report must be completed legibly, with all questions being completed fully. Consideration of the report will be delayed if Home Office officials have to return the report to seek clarification.

If the Home Office request clarification of any point in this report, this must be provided promptly.

Once completed this report must be faxed to the Home Office IRC Team.

A signed copy of this report must be placed on the detainee's medical record and another signed copy provided to the detainee free of charge.

The Home Office response must on receipt be reviewed by the medical practitioner. If it is considered to unsatisfactorily address the original concerns, it must be escalated to the Home Office IRC Team.

Notes – for the Home Office caseworker

You must consider and respond to this report in line with the guidance and instructions in:

- **Chapter 55b Immigration removals, enforcement and detention: general instructions – Adults at risk in immigration detention**
- **Detention services order (DSO) 9/2016 – Detention centre rule 35**

Appendix 6

Case Studies material references

Case Study D1527

File Reference	Video Reference	Title	Date	Time	Transcript
BBC00071	KENCOV1007	V2017042500021	25.04.2017	00:00-27:49	TRN0000002
BBC000091	KENCOV1012	V2017050400021	04.05.2017	17:45-29:59	TRN0000004
BBC000091	KENCOV1012	V2017050400022	04.05.2017	00:00-09:09	TRN0000006

Document Reference	Title	Date
CJS001129	Person Escort Record Form dated 4/4/17	04.04.2017
CJS001002	Patient Record of D1527 beginning 16.11.2016	
CJS000961	Mental Health Referral Form for detainee	04.04.17
CJS001049	Assessment review re D1527 dated 4.4.17 - 21.4.17	
CJS001035	Record of case reviews re D1527	
CJS001123	Home Office Rule 35(3) Report dated 13.4.2017	13.04.17
HOM000215	Letter from Duncan Lewis to Immigration Enforcement re Rule 35 Report and Adults at Risk policy	13.04.2017
HOM000644	Letter from OP Nexus High Harm Team (Home Office) to D1527 re Rule 35 report	18.04.2017
CJS001073	IS.91RA Part C: Supplementary Information to IS.91 RA Part A dated	24.04.2017

Document Reference	Title	Date
HOM000241	Two letters from Duncan Lewis Solicitors to Immigration Enforcement re medical records/mental health issues of D1527, 26 and 27 April 2017	
CJS001122	G4S Health Mental Health Referral Form for D1527	14.05.2017
CJS001073	IS.91RA Part C: Supplementary Information to IS.91 RA Part A	27.05.2017

Case Study D687

File Reference	Video Reference	Title	Date	Time	Transcript
BBC000070	KENCOV1016	V2017051300011	13.05.17	02:05 – 30:00	TRN0000095
BBC000070	KENCOV1016	V2017051300012	13.05.17	00:00 – 02:00	TRN0000095

Document Reference	Title	Date
CJS001139	G4S Gatwick IRCs D687's Medical Records, 28 April 2020	
CJS000848	Home Office R35 (3) Report	15.04.17
HOM000013	Home Office response to Rule 35 (3) report	26.04.17
CJS004810	Detention services security information report re D687	05.05.17
CJS000993	Care of at Risk Detainee ACDT Plan for D687	05.05.17 – 16.05.17
CJS005652	G4S Use of Force DC Rule 41 relating to D687 force	13.05.17
CJS001084	D687 Self harm incident investigation	13.05.17
CJS004810	Detention services security information report re D687	05.05.17

Case Study D720

File Reference	Video Reference	Title	Date	Time	Transcript
BBC000241	KENCOV1031	V2017060600006	06 June 2017	00:00-03:00	TRN0000089

Document Reference	Title	Date
CJS002045	D720 Patient Medical Records	
CJS001947	G4S Mental Health Referral Form D720	11.04.2017
CJS000845	Rule 35 report relating to D720	19.04.2017
CJS002457	D720 - Fit to Travel form	05.05.2017
CJS002148	D720 - G4S Health Fit to travel form	08.07.2017

Case Study D1538

File Reference	Video Reference	Title	Date	Time
No video footage provided for this case				

Document Reference	Title	Date
CJS003639	Medical Records - 01/01/2012 to 20/08/2017 - D1538	
HOM002624	Care and Separation - DCF 1 - DC Rule 40 for D1538	03.06.2017
CJS002901	Use of Force form for D1538	03.06.2017
HOM002629	Incident Report Part One for D1538 - 388/17	03.06.2017
CJS003308	G4S Fit to travel form re: D1538	14.06.2017
CJS003632	Rule 35 Report - D1538	24.07.2017
HOM0322007	Letter to D1538 from Home Office acknowledging receipt of a medical report	25.07.2017

Case Study D1914

File Reference	Video Reference	Title	Date	Time	Transcript
BBC000092	KENCOV1025	V2017052700012	27 May 2017	00:08-02:07	TRN0000087
BBC000092	KENCOV1025	V2017052700020	27 May 2017	05:27-23:42	TRN0000013; TRN0000014
BBC00583	KENCOV1044	V2017060600022	06 June 2017		TRN0000018

Document Reference	Title	Date
CJS000990	Detainee D1914 Patient Record, dated from 29/3/2017 to 27/08/2017	
CJS001043	HO Care of At Risk Detainees ACDT Plan re D1914	11.04.2017
CJS001033	IS91RA Part C	
CJS001144	G4S Health Letter from Dr Husein Oozeerally to Home Office confirming D1914 is fit to fly	12.04.2017
CJS004720	D1914 - Security Information Report	17.05.2017
HOM006304	D1914 Airline Risk Assessment	19.05.2017
CJS001160	Fitness to fly and detention letter re D1914 from Dr Husein Oozeerally to G4S and Home Office	27.05.2017
CJS004327	G4S Report of Injury to Detainee for D1914	27.05.2017
CJS004348	Incident Report in relation to D1914	27.05.2017
CJS004350	Incident Report in relation to D1914	27.05.2017
CJS001768	Detention services security information report re incident	28.05.2017

Document Reference	Title	Date
CJS004803	Detention services security information report re incident	28.05.2017
HOM006952	D1914 directions to remove a deportee	05.06.2017
HOM006566	Home Office Detention Review concerning D1914	16.06.2017
HOM010916	Home Office IS.91RA Part C - Supplementary Information Form	13.07.2017
CJS001024	Home Office Rule 35(1) Report	17.07.2017
HOM006799	Home Office IS.335 Letter: Acknowledge Receipt of Healthcare Report	25.07.2017

Appendix 7

Rule 35 (1) and (3) documents references

Reference	Detainee
CJS000827	D2741
CJS000828	D2374
CJS000829	D861
CJS000830	D1684
CJS000831	D154
CJS000832	D1210
CJS000833	D560
CJS000834	D481
CJS000835	D730
CJS000836	D24
CJS000837	D2092
CJS000838	D3066
CJS000839	D2986
CJS000840	D335
CJS000841	D871
CJS000842	D1487
CJS000843	D1884
CJS000844	D380
CJS000845	D720
CJS000846	D261
CJS000847	D812
CJS000848	D687
CJS000849	D1525

CJS000850	D1264
CJS000851	D556
CJS000852	D1413
CJS000853	D668
CJS000854	D949
CJS000855	D1106
CJS000856	D23
CJS000857	D1187
CJS000858	D3085
CJS000859	D1524
CJS000860	D2287
CJS000861	D727
CJS000862	D1286
CJS000863	D132
CJS000864	D128
CJS000865	D1384
CJS000866	D1590
CJS000867	D1143
CJS000868	D1459
CJS000869	D2442
CJS000870	D1330
CJS000871	D1091
CJS000872	D2567
CJS000873	D745
CJS000874	D1116
CJS000875	D2328
CJS000876	D2757
CJS000877	D1616
CJS000878	D2032

CJS000879	D2275
CJS000880	D1315
CJS000881	D1629
CJS000882	D1690
CJS000883	D1033
CJS000884	D647
CJS000885	D2834
CJS000886	D2155
CJS000887	D13
CJS000888	D735
CJS000889	D2214
CJS000890	D2013
CJS000891	D2890
CJS000892	D1000
CJS001024	D1914
CJS001123	D1527
CJS001918	D807
CJS002138	D12
CJS002208	D642
CJS002461	D523
CJS002765	D1432
CJS002920	D1225
CJS003632	D1538
CJS003858	D784
CJS003927	D1255