SUPPLEMENTARY REPORT

Brook House Inquiry

Report of	Dr James Hard MBBS FRCGP
Dated	January 2022
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. This is a Supplementary Report to that which I previously provided dated 18 November 2021 and should be read in conjunction with that report.

Dr James Jesse Hard

DPA

Contents

1. Introduction to the Supplementary Report

This is a Supplementary Report and should be read in conjunction with the first report provided to the Brook House Inquiry dated 18 November 2021. The first report was disclosed to core participants ahead of the hearings held in November and December 2021.

The Supplementary Report is based on additional documents and material that the Inquiry has received since the completion of the first report, as well as evidence arising from the first phase of hearings held in November and December 2021.

In light of the additional material provided, I have been asked to consider this additional material and provide further comments.

2. Issues to be addressed

I have set out the following areas for consideration as per the Letter of Instruction dated 20 December 2021:

2.1. *In your first report you expressed preliminary views in light of the evidence you had received at the time of writing. Please provide any further opinion you are able to express in light of the additional material now provided on the following paragraphs from your report:*

a. 5.72;

b. 5.165;

c. 6.1.1.6;

d. 6.1.2.1;

e. 6.1.2.3;

f. 6.1.2.4;

g. 6.1.3.2;

h. 6.2.3.11;

i. 6.3.1.2;

j. 6.3.3.1;

k. 6.3.3.9;

l. 6.3.4.3;

m. 6.3.4.4;

n. 6.3.5.3.

Rule 34 and 35

2.2. *Please consider the adequacy of the operation of the system with regard to the rule 35(1),*

rule 35(2) and rule 35(3);

a. *How did there come to be only a very small number of Rule 35(1) reports and no Rule 35(2) reports in the relevant period in light of other evidence of a high incidence of self-harm and / or suicide attempts, the number of detained persons managed on ACDTs and records indicating deterioration of the mental health of detained persons?*
b. *Should any of the rule 35(3) reports you have reviewed also have resulted in a rule 35(1) report? Where they did not, is it possible to ascertain the reasons why they did not? Please consider in particular the following detained persons' rule 35(3) reports in this regard: D1255, D2442, D2567, D1524, D13, D949;*
c. *Should any of the rule 35(3) reports you have reviewed also have resulted in a rule 35(2) report? Where they did not, is it possible to ascertain the reasons why they did not?*
d. *In relation to the rule 35(1) reports at paragraphs 5.18 and 6.2.3.1 please consider whether the system was operating adequately in terms of the timing and context of the reports, for example in relation to D801, in addition to the whether the content of the reports themselves was adequate;*
e. *Whether the concern expressed at paragraph 5.57 regarding duplication and administrative burden regarding the three limbs of rule 35 could be overcome by redesigning the form to allow one report to be made under multiple limbs.*

2.3. *In terms of the adequacy of the training at Brook House regarding Rule 34 and 35 (and other related matters such as the Adults at Risk Policy) generally and in particular for GPs to fulfil their role:*

f. *Please further consider whether the fact that there are so few rule 35(1) reports and no rule 35(2) reports during the relevant period is indicative of systemic gaps in the training of GPs and other clinicians (note, by way of example only, that the training slides at [HOM002581] hardly mention Rules 35(1) and (2) at all);*

g. *Please consider whose responsibility it is to rectify this gap in training and awareness. Consider the extent to which GPs themselves, embarking upon immigration removal centre work, should take it upon themselves to inform themselves about these Rules, and other relevant matters given their professional and regulatory duties. To what extent should this duty extend to obtaining and reading the Detention Centre Rules, and the Adults at Risk policy? Within what timeframe might one reasonably expect a GP in a removal centre to have obtained and familiarised themselves with these requirements?*

h. *What training or support is necessary to ensure that GPs maintain their independence in fulfilling their role in the rule 34 and 35 process?*

i. *Do you consider a GP's independence is impacted where there is a financial interest in play under the contract to provide GP services in the centre?*

j. *Are there safeguards that might be built into the contract to ensure independence and professionalism?*

Adults at Risk Policy

2.4. *Please consider the Adults at Risk Policy and statutory guidance provided. Please consider paragraph 6.2 of your report. Please provide any further conclusions on the efficacy / effectiveness of the Adult at Risk framework in light of the additional material.*

2.5. *Please comment upon whether the introduction of the requirement of detention being likely to cause harm in order to be classed as level 3 evidence under the Adults at Risk Policy re-introduces the previously removed "whether someone with serious mental illness cannot be satisfactory managed in detention" requirement from the previous system? Consider the cases of D149 and D1798.*

2.6. *What can or might be done to avoid or address the desensitisation referred to in the report at paragraph 6.2.1.3?*

Food and Fluid Refusal

2.7. *Please consider the relationship between food and fluid refusal and self-harm and / or deterioration in mental health of detained persons (see in particular at para 6.3.5.5). Does the system for the management of food and fluid refusal adequately address the underlying causes for food and fluid refusal by detained persons?*

Relationship with Healthcare

2.8. *Please consider further the nature of the relationship between healthcare and the Home Office and between healthcare and G4S during the relevant period.*

Adequacy of Mental Health Provision

2.9. *Please provide any further conclusions on the adequacy of mental health provision in Brook House during the relevant period.*

D687 Case Study

2.10. *In relation to the D687 case study please consider Dr Galappathie's report dated 22 September 2021. Please then consider: k. Dr Galappathie's view that Dr Oozeerally should have taken steps to ensure D687 received anti-depressants (as did occur, but only after D687 transferred to the Verne) (see Dr Galappathie at paragraph 193).*

k. What Dr Galappathie says about Dr Oozeerally alerting officers to the possible need for an ACDT. Do you agree that D687 should have been managed on an ACDT?

l. Should Dr Oozeerally have opened an ACDT himself at this stage?

m. Should Dr Oozeerally have written a Rule 35(2) report? If it is your view that a rule 35(2) report was not necessary at this stage please explain why.

n. Should Dr Oozeerally have written a Rule 35(1) report? Was there sufficient consideration of whether D687 was deteriorating in detention? If it is your view that a Rule 35(1) report was not necessary at this stage, please explain why.

3. Summary of my conclusions

This report will show that having reviewed the additional material provided to date, that during the relevant period:

3.1. As set out in my original report dated 18 November 2021, it was my opinion that the system for Rule 35 and Adults at Risk policy was inadequate during the relevant period. The additional material provided for this Supplementary report has further consolidated these views.

3.2. As set out in my original report dated 18 November 2021, it was my opinion that the training and education of staff in the Use of Force, ACDT and Rule 35 was inadequate. The additional material provided for this Supplementary report has further consolidated these views.

3.3. As set out in my original report dated 18 November 2021, it was my opinion that the deficiencies that I identified did not directly result in the mistreatment of detained persons but that overall, there was an inadequate system for the prevention of mistreatment of detained persons. The additional material provided for this Supplementary report has further consolidated this view.

3.4. Based on the additional material provided and the further observations within this report, I have made a number of high-level suggestions in order to try and address some of these issues.

4. Opinion

Below, I have set out my responses in regard to the areas I have been asked to consider within the Letter of Instruction dated 20 December 2021:

4.1. Regarding any further opinion in light of the additional material provided on the following paragraphs from the first report:

a. Paragraph 5.72;

… 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.

- I have not been able to locate anything within the additional material or in Dr Oozeerally's witness statement[1] that explains or clarifies the intended meaning in this statement in his Rule 35 report for D1527, and therefore it remains unclear.

b. Paragraph 5.165;

[1] DRO000001 - BH Husein Oozeerally statement 15 12 2021 - Tracked Changes

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.

- The witness statement[2] of the Head of Healthcare and Registered General Nurse, Sandra Calver stated that where there was concern for the welfare of the individual during a Use of Force, nurse Buss should have used a phrase such as *"Hands off emergency"* in order to convey to the custodial staff that their manoeuvre was having an adverse impact on the detained person.

- In paragraphs 35 and 37 of his witness statement[3], Callum Tulley stated that he could not confirm whether or not nurse Jo Buss could in fact see the hold being applied by custody officer Jan Paschali during the Use of Force on D1527 on 25 April 2017. However, he does confirm that there was no apparent attempt by nurse Jo Buss to check D1527's welfare or intervene during this incident.

[2] DWF000009 – Sandra Calver (Head of Healthcare, Head of IRCSs) - signed statement, dated 09.11.2021
[3] INQ000051 – Exhibit CT1 19.08.21.pdf - Home Office CTC Clearance letter addressed to Callum Tulley; other documents consist of his DCO Certification; Health & Safety Award & Two separate Witness Statements dated 27/08/2019 & 13/12/2019

- I maintain my view that nurse Buss failed in her duty to adequately monitor the welfare of D1527 during the Use of Force or subsequently intervene when Jan Paschali used an unapproved restraint method.

c. Paragraph 6.1.1.6;

The management of healthcare staff

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.

- The witness statements of Head of Healthcare, Sandra Calver[4] and Deputy Practice Manager, Michael Wells[5] are useful for their description of the management structure within the healthcare service in Brook House during the relevant period.

- These statements are also helpful in providing a more detailed view of the operational aspects of the management of the healthcare service within Brook House Immigration Removal Centre.

[4] DWF000009 – Sandra Calver (Head of Healthcare, Head of IRCSs) - signed statement, dated 09.11.2021
[5] DWF000004 – Signed Witness Statement – Michael Wells (Senior Practice Manager at Brook House and Tinsley House), dated 05.11.2021

- The witness statements of the remaining members of the nursing team do not raise any specific concerns in regard to the management of the healthcare staff during the relevant period.

- Overall, it is my opinion that the day-to-day management of healthcare staff within Brook House was adequate during the relevant period. I have reached this conclusion on the basis that the organisation and structure of the healthcare management team that was in place was in keeping with what I would have expected and that they were aware of and involved in all of the relevant aspects of the healthcare provision during the relevant period that I would have otherwise expected to have seen.

d. Paragraph 6.1.2.1;

Relationships between healthcare and other entities in Brook House

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 witness statements of the healthcare management and the nursing staff within Brook House during the relevant period provide a more detailed view of the relationships between healthcare and other entities in Brook House.

- In particular, the views provided within these statements consistently indicate that during the relevant period, the relationship between healthcare and custodial staff was largely cooperative and there was no consistent theme of an inadequate or dysfunctional relationship during the relevant period.

- In regard to the relationship between healthcare staff and the Home Office staff within Brook House, there was some variability within the views provided. It was noted that within the witness statements[6] that whilst there was an adequate relationship with the Home Office staff, the understanding of Home Office staff roles and responsibilities could have been improved during the relevant period. It was highlighted that at times that Home Office staff exerted pressure[7][8] on some the healthcare staff in relation to their requirement for the provision of information or the amendment of relevant documents.

e. Paragraph 6.1.2.3;

Relationships between healthcare and other entities in Brook House

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

[6] DWF000009 – Sandra Calver (Head of Healthcare, Head of IRCs) - signed statement dated 09.11.2021
[7] DWF000013 – Signed Witness Statement – Emily Parr (Registered Nurse), dated 16.11.2021
[8] INQ000058 – Final Witness Statement of Jacintha Dix (Healthcare Practice Manager) in response to Rule 9 request by the Inquiry, dated 04/11/21

until such time that I receive further documentation allowing me to comment further on this aspect of the Inquiry.

- In regard to the other entities within Brook House, there was no evidence that there were systemically inadequate relationships between the healthcare staff and the Independent Monitoring Board, the Gatwick Detainees Welfare Group, Medical Justice, Bail for Immigration Detainees or any other external organisations during the relevant period.

f. Paragraph 6.1.2.4;

Relationships between healthcare and other entities in Brook House

On one occasion, there was video footage evidence 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 (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…

- The additional material provided has not provided any evidence in the alternative or further clarification on this point.

- Therefore, I maintain my view that nurse Jo Buss failed in her duty to adequately monitor D1527 and/or intervene during this incident and to make accurate records of the incident in the appropriate manner.

g. Paragraph 6.1.3.2;

Whether appropriately qualified clinicians were employed

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.

- The additional material provided within the witness statements indicates that the healthcare staff employed during the relevant period were appropriately qualified.

h. Paragraph 6.2.3.11;

Operation of Rule 35

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.

- The additional material provided has not brought to light any evidence that Rule 35 (2) reports were considered or utilised in either of these cases.

- I have provided my detailed opinion on matters relating to the use of Rule 35 (2) during the relevant period below.

i. **Paragraph 6.3.1.2;**

The extent and suitability of health provision

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.

- According to the additional material provided by NHS England, it appears that the expected mechanisms were in place during the relevant period in regard to the oversight of the contract for the delivery of the health services within Brook House.

In particular, these are also described in paragraphs 11 and 16 of the witness statement of Nicholas Watkins[9].

- In my opinion, the additional material provided demonstrates that during the relevant period, the mechanisms for the monitoring of the overall quality of the healthcare service contract were adequate and appears to have been operating appropriately. I have reached this conclusion on the basis that the quarterly Contract Review[10][11][12] meetings during the relevant period were well-attended and covered the expected range of topics and issues that I would have expected to have seen. In addition, there were regular quarterly Quality Committee[13][14][15][16] meetings during the relevant period which also appeared to be well-attended and covered the expected range of topics and issues that I would have expected to have seen. I have been provided two sets of minutes from the Gatwick IRC Strategic Partnership Board[17][18] minutes which appeared to be well-attended and covered the expected range of topics and issues that I would have expected to have seen.

j. Paragraph 6.3.3.1;

[9] NHS000054 – Witness Statement of Nicholas Watkin (Head of NHS England Health and Justice in the South East), dated 15.11.2021
[10] NHS000039 – Quarterly Contract meeting 16 March 2017
[11] NHS000040 – Quarterly Contract meeting 22 June 2017
[12] NHS000041 – Quarterly Contract meeting 31 October 2017
[13] NHS000042 – Quarterly Quality Meeting Minutes 10 January 2017
[14] NHS000043 – Quarterly Quality Meeting Minutes 11 April 2017
[15] NHS000045 – Quarterly Quality Meeting Minutes 18 July 2017
[16] NHS000047 – Quarterly Quality Meeting Minutes 31 October 2017
[17] NHS000031 – Gatwick IRCs Strategic Partnership Board Meeting minutes 23 June 2017
[18] NHS000029 – Gatwick IRCs Strategic Partnership Board Meeting minutes 12 December 2017

Medication and prescription management

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.

- The additional material provided has not demonstrated any deficiencies in the system for the provision of medication within Brook House during the relevant period.

- Overall, it is my view that the management of prescriptions and medication within Brook House during the relevant period was adequate.

k. Paragraph 6.3.3.9;

Medication and prescription management

D720

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.

- The additional material provided has not demonstrated any deficiencies in the system for the provision of medication within Brook House during the relevant period.

- Overall, it is my view that the management of prescriptions and medication within Brook House during the relevant period was adequate. From the additional material provided, I have not identified any evidence that there were any significant deficiencies or delays between the prescribing of medication and the subsequent administration to detained persons.

I. Paragraph 6.3.4.3;

Clinical management of self-harm

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 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.

- I have provided my detailed opinion on matters relating to self-harm and the use of ACDT during the relevant period below.

m. Paragraph 6.3.4.4;

Clinical management of self-harm

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.

- I have not seen any evidence within the additional material provided that has altered the view I provided in my original report in regard to the specific case of D1527.

- However, I have provided my detailed view on matters relating to the management of self-harm below.

n. Paragraph 6.3.5.3.

Clinical management of food and fluid refusal

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 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.

- I have not seen any evidence within the additional material provided that has demonstrated that there was an adequate system in place for the auditing of the procedures in place in regard to the policies in place for the management of food and fluid refusal.

- I have provided my detailed view on matters relating to the management of food and fluid refusal below.

Rule 34 and 35

4.2. Regarding the adequacy of the operation of the system with regard to the rule 35(1), rule 35(2) and rule 35(3):

a. How did there come to be only a very small number of Rule 35(1) reports and no Rule 35(2) reports in the relevant period in light of other evidence of a high incidence of self-harm and / or suicide attempts, the number of detained persons managed on ACDTs and records indicating deterioration of the mental health of detained persons:

- As outlined my original report, the material provided indicated that there were only two Rule 35 (1) reports and no Rule 35 (2) reports during the relevant period. I have not yet been provided with a clear explanation as to the reasons why these particular reports were not utilised when, in my view, the case studies indicated that the threshold for their use had been met according to my understanding of the Detention Centre Rules. In regard to the case of D801, a Rule 35 (1) report was provided, but there appeared to be a delay in the completion of this report and notifying the Home Office utilising this mechanism. .

- With particular reference to the case studies for D1914, D687 and D1527, the use of Rule 35 (1) and Rule 35 (2) does not appear to have been undertaken when there was an apparent deterioration in the detained person's condition.

D1914:

  - On 05 July 2017[19], D1914 was noted to have self-harmed by making cuts to

[19] Paragraph 5.296. of the Report dated 18 November 2021

his arms and neck and taken an overdose of his medication. Whilst an ACDT was opened, there was no corresponding Rule 35 (2) report apparently provided to the Home Office to notify them of this change in his circumstances. Additionally, there was no Rule 35 (1) report notifying the Home Office of his apparent deterioration on this occasion. In my view and based on my understanding of the Detention Centre Rule 35, there should have been a Rule 35 (1) and Rule 35 (2) on this occasion.

- On 13 July 2017[20], Dr Chaudhary completed an IS.91 RA Part C relaying his concerns to the Home Office of the risk of his condition worsening in detention but notably, there was no Rule 35 (1) completed on this occasion. Subsequently, however, the Rule 35 (1) was completed by Dr Oozeerally on 17 July 2017. In my view and based on my understanding of the Detention Centre Rule 35, there should have been a Rule 35 (1) on this occasion.

D687

- On 15 April 2017[21], Dr Oozeerally completed a Rule 35 (3) report for D687 but did not provide an opinion in regard to the impact of ongoing detention at this stage. In my view, Dr Oozeerally should have provided his opinion in regard to the impact of detention on D687 in this Rule 35 (3) report. Despite this, the Home Office's response concluded that D687 met the threshold for an Adult at Risk but that their decision was to maintain detention at that time. I have provided further comments below in regard to Dr Oozeerally's involvement with D687 in my responses to the questions arising from Dr

[20] Paragraph 5.311. and Paragraph 5.312 of the Report dated 18 November 2021
[21] Paragraph 5.179. and Paragraph 5.180 of the Report dated 18 November 2021

Galappathie's report.

- On 05 May 2017[22], D687's condition was noted to have deteriorated, and he was placed on an ACDT as a result of a reported intention to take an overdose. An appointment was made for D687 to see the GP on 10 May 2017, which he did not attend. There was no subsequent Rule 35 (2) report provided to the Home Office notifying them of D687's apparent suicidal ideation. Additionally, there was no Rule 35 (1) report notifying the Home Office of the apparent worsening impact as a result of ongoing detention on D687. In my view, consideration should have been for the assessment and provision of a Rule 35 (1) and Rule 35 (2) reports based on the apparent deterioration. Based on my understanding of the Detention Centre Rules and that the Rule 35 reports must be completed by a 'medical practitioner', it is my view that the missed appointment on 10 May 2017 ought to have been followed up with a further appointment with the GP in order for them to assess the detained person and complete the relevant Rule 35 (1) and/or Rule 35 (2) reports. In the absence of another member of staff being able to provide the report, and in the circumstances that the GP was either unavailable at that time or the detained person remained unwilling to attend for an assessment, then in my view the GP should have completed the necessary report(s) based on the available records, notifying the Home Office of the change in circumstances.

[22] Paragraph 5.183. and Paragraph 5.185. and Paragraph 5.186. of the Report dated 18 November 2021

- On 13 May 2017[23] during an apparent planned transfer to the Verne IRC, D687 protested by placing a ligature around his neck. This was subsequently removed during a Use of Force.

- There is no entry in the SystmOne clinical records indicating that the ACDT was opened whilst D687 was still in Brook House. It appears that following this particular incident, D687 was successfully transferred to The Verne IRC and according to the additional SystmOne records[24] provided, he was subsequently placed on an ACDT at The Verne IRC. In my opinion, the ACDT ought to have been commenced at Brook House following the attempted ligature. Based on my understanding of the Detention Centre rules, it is my view that this incident also ought to have prompted the provision of a Rule 35 (2) report at that time whilst still in Brook House. I note that following transfer to The Verne and the subsequent commencement of the ACDT, there does not appear to have been a Rule 35 (2) report provided.

D1527

- When D1527 arrived in Brook House on 04 April 2017[25], he was already on an ACCT document within HMP Belmarsh. This prompted the commencement of the ACDT process within Brook House on that day.

[23] Paragraph 5.190. of the Report dated 18 November 2021
[24] HOM002457 – Medical Records of D687 including time at Brook House, 26/10/2017
[25] Paragraph 5.61. and Paragraph 5.62. and Paragraph 5.53. of the Report dated 18 November 2021

- Although D1527 was seen by Dr Chaudhary on 05 April 2017[26], he does not appear to have provided a Rule 35 (2) report on this occasion notifying the Home Office of D1527's history of self-harm and suicidal ideation. Given that D1527 was on and ACDT, in my view and based on my understanding of the Detention Centre Rule 35, there should have been a Rule 35 (2) on this occasion.

- A Rule 35 (3) report completed by Dr Oozeerally on 13 April 2017[27] referred to the fact that D1527 was on an ACDT document at the time of his assessment but did not result in the provision of a Rule 35 (2) report in regard to the ongoing thoughts of suicide. Notably, Dr Oozeerally commented that he was *"unsure"* as to whether detention was having a negative impact on D1527, which would explain why there was no Rule 35 (1) report provided on this occasion. However, based on the information provided within the records and the Rule 35 (3) report, it is my view that Dr Oozeerally ought to have considered providing a Rule 35 (1) on the basis that he held the view that D1527 *"may"* have been a victim of torture and he should have considered providing a Rule 35 (2) report on the basis that D1527 was on an ACDT at the time of his assessment. I have not been able to locate anything within the additional material or in Dr Oozeerally's witness statement that provides an explanation as to why he did not consider a Rule 35 (1) and/or Rule 35 (2) on this occasion.

[26] Paragraph 5.65. of the Report dated 18 November 2021
[27] Paragraph 5.71. of the Report dated 18 November 2021

- The response from the Home Office on 18 April 2017[28] concluded that detention would be maintained on the basis that the negative immigration factors outweighed the level of D1527's level of vulnerability.

- The records show that D1527 remained on an ACDT and was subsequently apparently refusing food. D1527 then self-harmed by making cuts to his wrist on 24 April 2017[29]. These additional factors in D1527's case were not apparently relayed to the Home Office through the use of a Rule 35 (1) or Rule 35 (2) report. Based on the information provided within the records and my understanding of the Detention Centre Rule 35, it is my opinion that there should have been a Rule 35 (1) on this occasion, highlighting the apparent deterioration.

- On the following day, 25 April 2017[30], D1527 was subjected to a Use of Force when he attempted to ligature and swallow a battery. D1527 was moved to E wing for closer observation. D1527 was seen by Dr Oozeerally on E wing on 26 April 2017[31]. Despite the events of the previous day and subsequent move to E Wing, the Home Office were not notified by Dr Oozeerally through the use of a Rule 35 (1) and/or Rule 35 (2) report on this occasion. Based on the information provided within the records and my understanding of the Detention Centre Rule 35, it is my opinion that there should have been a Rule 35 (1) and Rule 35 (2) highlighting the apparent deterioration and suicide attempt on this occasion.

[28] Paragraph 5.77. of the Report dated 18 November 2021
[29] Paragraph 5.85. of the Report dated 18 November 2021
[30] Paragraph 5.92. of the Report dated 18 November 2021
[31] Paragraph 5.96. of the Report dated 18 November 2021

- The SystmOne records show that following this incident, D1527 continued to be observed on an ACDT and continued to refuse food but that despite this ongoing deterioration in his presentation, there was no Rule 35 (1) report provided to the Home Office. Based on the information provided within the records and my understanding of the Detention Centre Rule 35, it is my opinion that there should have been a Rule 35 (1) in view of this deterioration.

- My understanding of the Detention Centre Rules is that where there was an apparent deterioration of a detained person's health as a result of ongoing detention, there ought to have been a Rule 35 (1) report provided to the Home Office notifying them of this and that this ought to have been provided by the 'medical practitioner'.

- My understanding of the Detention Centre Rules is that where there was an apparent deterioration and the detained person had suicidal ideation, there ought to have been a Rule 35 (2) report provided to the Home Office and that this ought to have been provided by the 'medical practitioner'.

- One of the aspects highlighted by the case studies is the apparent disconnect between the information known by the healthcare staff and their ability to ensure that a review by a 'medical practitioner' was both timely and that it prompted the provision of the Rule 35 (1) and Rule 35 (2) reports where appropriate, particularly where there was apparent deterioration in a detained person's mental health

and/or there had been an episode of self-harm or attempted suicide.

- There are several issues arising from these case studies. Firstly, it appears that there was no system in place for the automatic review of a detained person where there was self-harm, suicide attempt and/or apparent deterioration. Secondly, it appears that when the 'medical practitioner' (the GP) was asked to review cases where there was self-harm, suicide attempt and/or apparent deterioration, there was no systematic approach to the use of Rule 35 (1) or Rule 35 (2) reports in order to notify the Home Office of these changes in presentation. Thirdly, there does not appear to have been any mechanism by which the detained person's circumstances were systematically reviewed by the GP in order to consider whether or not their condition had changed over time and whether detention was having an impact.

- In my opinion, the material provided indicates that there was a lack of clarity on the part of the GPs as to the use of the Rule 35 (1) and Rule 35 (2) reports during the relevant period. In my view, this may have been in part as a result of a failure of the healthcare staff to trigger the review at the earliest opportunity and have been partly because the GPs were not considering the provision of these reports when the opportunity arose during the relevant period. As a result, it is my view that these issues contributed to an inadequate use of the system and would have led to a delays/failure in the notification of these issues to the Home Office.

b. Should any of the rule 35(3) reports you have reviewed also have resulted in

a rule 35(1) report? Where they did not, is it possible to ascertain the reasons why they did not? Please consider in particular the following detained persons' rule 35(3) reports in this regard: D1255, D2442, D2567, D1524, D13, D949:

- My understanding of the Detention Centre Rules is that a Rule 35 (1) report ought to have been completed where the findings within the assessment section 6 of the Rule 35 (3) indicated that the detained person's health was likely to be injuriously affected by continued detention.

D1255

- A Rule 35 (3) report dated 22 March 2017[32], was completed at Heathrow Immigration Removal Centre by Dr Abu-Sufian Jabbar. The summary provided within section 6 of the Rule 35 (3) report stated: *'In view of the account he has given me today and the vulnerability of him we are very concerned about this. He is under the psychiatrist and the mental health team who will be able to provide a detailed account of his mental health and psychological wellbeing'*. According to the SystmOne records[33], D1255 was initially held in Morton Hall IRC (records commence on 20 January 2017) and then transferred to Heathrow IRC on 25 February 2017 followed by transfer to Brook House IRC on 24 March 2017. According to the entry on 04 April 2017 at 13:58 by Dahlia McNaught-Dowd (on behalf of consultant psychiatrist Dr Belda), it appears that a Section 48 was required in respect of a further assessment in a hospital environment owing to the possibility of an underlying psychosis (in addition to Autistic Spectrum Disorder). It

[32] CJS003927 – Rule 35 report re: D1255, dated 22 March 2017
[33] CJS003870 – G4S Gatwick IRCs Medical Records D1255, 24 April 2020

is not entirely clear from the records provided whether D1255 was in fact transferred or released from Brook House.

- In keeping with my understanding of the Detention Centre Rules, it is my opinion that a Rule 35 (1) report should have been completed in order to notify the Home Office of the apparent deterioration whilst in detention.

D2442

- A Rule 35 (3) report[34] for D2442 was completed on 11 April 2017. Section 4 of the report: *'... He has recently been started on mirtazapine due to low mood and thoughts of ending life. He is under the care of the mental health team. 2 days ago he says that he tried to hang himself, He has not previously disclosed this to anyone. He says he mentioned this at the airport when he arrived'* and section 5: *'2 visible scars - Thoughts of ending life recently since being in detention - He appears anxious about his case. - At consultation, no evidence of severe mental health issues'*.

- The summary provided within section 6 of the Rule 35 (3) report stated: *'He may be a victim of torture. His scars are consistent with the account given'*.

- I have not been provided with the SystmOne records for D2442. It is not clear whether the findings on this Rule 35 (3) report culminated in a Rule 35 (1) report or whether the Home Office considered the findings in section 4, 5 and 6 of the Rue

[34] CJS000869 – Rule 35 report relating to D2442, dated 11/04/2017

35 (3) report and arranged for the detained person to be released on this basis.

- Given the history recorded within the Rule 35 (3) report, as per my understanding of the Detention Centre Rules, I would have expected a Rule 35 (2) report to have been provided notifying the Home Office of the suicidal ideation noted at the time of making this report.

D2567

- A Rule 35 (3) report[35] was completed on 13 April 2017. Section 6 of the report concluded: *'He describes a 3 year period of slavery with periods of physical and* Sensitive/Irrelevant *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'.*

- Given the history recorded within the Rule 35 (3) report, as per my understanding of the Detention Centre Rules, I would have expected a Rule 35 (1) report to have been provided notifying the Home Office of the history of likely deterioration at the time of making this report.

D1524

- A Rule 35 (3) report[36] was completed on 25 April 2017. Section 6 of the report concluded: *'He gives an account of torture and his scarring is consistent with this account. He is very likely to be a victim of torture. He is having difficulty sleeping but currently prolonged detention has not been seriously adverse to his health'.*

[35] CJS000872 – Rule 35 report – Detainee D2567, dated 13/04/2017
[36] CJS000859 – Rule 35 report – Detainee D1524, dated 25/04/2017

- I have not been provided with the SystmOne records for D1524. It is not clear whether this Rule 35 (3) report was considered by the Home Office in respect of possible release from detention on this basis.

- Given the history recorded within the Rule 35 (3) report, as per my understanding of the Detention Centre Rules, I would not have expected a Rule 35 (1) report to have been provided to the Home Office given that detention had not been noted to have had an adverse impact at this stage. However, in my opinion, where in this case it has been clearly highlighted in the Rule 35 (3) report that D1524 was *"very likely"* to have been a victim of torture, I would have expected there to have been a system in place in order to re-evaluate the impact of detention periodically in order to establish whether any deterioration had taken place. None of the material provided to date has demonstrated a specific systematic approach to the re-evaluation of detained persons who have been identified as vulnerable in order to ascertain whether ongoing detention was having a negative impact upon them. In my view, it would be difficult to reliably predict the rate at which a detained person who has been a victim of torture might deteriorate and/or whether specific factors, such as delays or unwanted outcomes in regard to immigration status and possible deportation might play a part. However, it is also the case that the extant mechanisms did not appear to reliably generate a review in respect of the Rule 35 (1) process. In my view, it would be critically important to keep under regular review any detained person who had been a victim of torture but whose detention had been maintained by the Home Office following the provision of a Rule 35 (3) report in order to consider whether a Rule 35 (1) report was necessary. Having

determined that D1524 was a victim of torture, and that by the definition within the Adults at Risk policy that he was a vulnerable detainee, it is my view that the existing ACDT mechanism could have been used to ensure an appropriate review process was in place to detect any deterioration as a result of ongoing detention.

- Equally, it could be said that where a Rule 35 (3) report did clearly conclude that the detained person had been a victim of torture then a Rule 35 (1) ought to have been automatically generated. However, I note the absence of any requests by the Home Office for the completion of a Rule 35 (1) report from the GP when they had articulated their view that the detained person was likely to have been a victim of torture. I have not been provided with any material explaining why the Home Office did not request the completion of a Rule 35 (1) report following the provision of a Rule 35 (3) report where the detained person has been identified as a victim of torture.

D13

- A Rule 35 (3) report[37] was completed on 27 April 2017. Section 6 of the report concluded: *'He describes a prolonged period of torture. He has a large number of scars consistent with the methods of torture described in this account. He may be a victim of torture. I am unable to comment on his mental health ongoing but at present I have no acute concerns'.*

[37] CJS000887 – Rule 35 report - Detainee D13, dated 27/04/2017

- I have not been provided with the SystmOne records for D13. It is not clear whether this Rule 35 (3) report was considered by the Home Office in respect of possible release from detention on this basis. Based on the information provided within the Rule 35 (3) report, it is my view that this should have prompted the provision of a Rule 35 (1) report to the Home Office.

- On this occasion, the GP provided a less confident conclusion that the detained person had been a victim of torture conflicting with the preceding sentences in section 6. I would have expected this to have been confusing for the Home Office caseworker. I am not aware as to whether there was a reasonable or reliable mechanism by which clarification could be sought from the GP who wrote the report. In my view, and as I have opined in my original report[38], there does not appear to have been a suitable mechanism for the quality assurance and quality improvement activities that would be necessary for ensuring that the Rule 35 processes were fit for purpose.

- As outlined in the case above, there also does not appear to have been a specific system in place for the re-evaluation of detained persons who have been identified as possible victims of torture in order to ascertain whether ongoing detention was having a negative impact upon them.

D949

[38] Paragraph 5.38., Paragraph 5.49., Paragraph 6.2.4.3. and Paragraph 6.5.1.3. of the Report dated 18 November 2021

- A Rule 35 (3) report[39] was completed on 03 August 2017. Section 6 of the report concluded: *'He may be a victim of torture. He appears credible and his scars are consistent with the account he gives. He has mental health issues and is currently on antidepressants and under mental health team. He appears anxious. His health may deteriorate with on-going detention'.*

- I have not been provided with the SystmOne records for D949. It is not clear whether this Rule 35 (3) report was considered by the Home Office in respect of possible release from detention on this basis.

- In this case, the GP provides their view that the detained person *'may'* have been a victim of torture and that his health *'may'* deteriorate with ongoing detention. However, it has not been made clear by the GP on this occasion whether their view that deterioration may occur because of the underlying mental health issues or because of the possible history of torture or both. In either scenario, it is my view based on my understanding of the Detention Centre Rules that a Rule 35 (1) report ought to have been provided to the Home Office on this occasion.

c. Should any of the rule 35(3) reports you have reviewed also have resulted in a rule 35(2) report? Where they did not, is it possible to ascertain the reasons why they did not:

[39] CJS000854 – Rule 35 report – Detainee D949, dated 03/08/2017

- Section 2 of the Rule 35 (2) report indicates: *'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 is suspected of having suicidal intentions'.*

- Section 3 of the Rule 35 (2) report requests the writer under relevant information to answer 5 questions:
    - *i) Please state the reasons for suspecting that the detainee has suicidal intentions?*
    - *ii) Is the detainee being managed under Assessment Care in Detention Teamwork (ACDT) arrangements? If not, why not?*
    - *iii) Can the suicide risk be managed/reduced satisfactorily through ACDT, medication and/or appropriate interventions such as talking therapies?*
    - *iv) What arrangements might be needed to manage the detainee's suicide risk in a non-detained setting?*
    - *v) Has there been a mental health assessment? If so, what was its 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.*

- My understanding of the Detention Centre Rules is that where the assessment of a detained person for a Rule 35 (3) report detected suicidal ideation, then it would have been expected for a Rule 35 (2) report to have been made in order to notify the Home Office of this specific concern (above and beyond that of the evidence of torture and the impact of detention).

- I have not located any particular Rule 35 (3) reports within the case studies that ought to have resulted in a Rule 35 (2) report based on the content provided within them specifically. The Rule 35 (3) report for D2442 does refer to suicidal ideation and therefore in my view ought to have prompted the completion of a Rule 35 (2) report in addition.

- As I have highlighted above, it is my view that the mechanism for the generation of a Rule 35 (2) report in response to suicidal ideation does not appear to have been working effectively.

- In relation to the case studies, and outside of the generation of the Rule 35 (3) reports, it is my view as outlined above that the cases of D687, D1527 and D1914 should have prompted the completion of a Rule 35 (2) report based on my understanding of the Detention Centre Rules.

d. In relation to the rule 35(1) reports at paragraphs 5.18 and 6.2.3.1 please consider whether the system was operating adequately in terms of the timing and context of the reports, for example in relation to D801, in addition to the whether the content of the reports themselves was adequate:

- In my original report[40], I stated that *'on initial inspection, system for undertaking Rule 35 (1) and Rule 35 (3) reports appeared to be adequate'*, but that there was notably only very few Rule 35 (1) reports provided during the relevant period and that Rule 35 (3) reports were often lacking an adequate conclusion[41] in regard to the impact of detention.

- Based on the material provided, it is my view that Rule 35 (3) and Rule 35 (1) are inherently linked. My understanding of the Detention Centre Rules is that where the assessment of a detained person for a Rule 35 (3) report concluded that the detained person was likely to have suffered ill-treatment or been a victim of torture then a Rule 35 (1) report ought to have been completed.

D801

- The SystmOne records for D801[42][43] indicate that he arrived in Brook House on 01 March 2017. The assessment conducted by healthcare assistant Eaven Owens on 01 March 2017 at 13:29 indicated that D801 had previously been *'... diagnosed with PTSD as a result of being a victim torture...'* and *'... ACDT opened due to*

[40] Paragraph 6.2.3.1. of Report dated 18 November 2021
[41] Paragraph 6.2.3.6. of Report dated 18 November 2021
[42] HOM032191 – D801 Patient Record 31.01.17 to 03.04.2017 whilst at Gatwick IRC, Pages 6-17 of 55 only
[43] HOM032192 – Pages 19-46 of 55 of Patient Records from Gatwick IRC for D801 between 2 March 2017 and 30 March 2017

increased risk of self-harm…'. The plan recorded by Eaven Owns included referral to the GP and the mental health team. D801 was noted to have not attended the appointment with the GP at 15:55 on 01 March 2017. The reason for D801's *'Did not attend'* has not been recorded. It does not appear that despite the reported history of torture that a specific appointment was made at that time for one of the GPs for the provision of a Rule 35 (3) report.

- On 02 March 2017 at 15:18, D801 was seen by consultant psychiatrist Dr Belda along with RMN (presumably mental health nurse Karen Churcher as the entry is recorded in her name) and Beverly Baldwin, deputy director for Adult Services at SPFT [Sussex Partnership NHS Foundation Trust]. Dr Belda noted in his consultation that D801 reported that he was *'… severely tortured'*. Dr Belda's plan included a Section 48 [of the Mental Health Act] transfer to LGH [Langley Green Hospital] and the commencement of Sensitive/Irrelevant 45mg.

- On 02 March 2017 at 15:29, there was an entry recorded by Dr Saeed Chaudhary who recorded: *'Pt was on* Sensitive/Irrelevant [sic] *45mg, advised to continue, prescribed not in possession. Not suicidal, but having depression. Continue* Sensitive/Irrelevant *and review if not improving'*. It is not clear whether Dr Chaudhary saw D801 in-person on this occasion.

- In my opinion, it is of particular note that neither Dr Belda nor Dr Chaudhary made reference to the need for the provision of a Rule 35 (3) report in respect of the apparent history of torture in order to notify the Home Office of this history. Furthermore, given the apparent concern raised by Dr Belda that D801 required a

transfer under Section 48 of the Mental Health Act, it is of particular note that neither Dr Belda nor Dr Chaudhary made reference to the need for the provision of a Rule 35 (1) report notifying the Home Office of any concerns in relation to continued detention on this occasion. This point raises a further issue not covered elsewhere in the original report or this supplementary report and relates to the interpretation of the term 'medical practitioner' within the Detention Centre Rules. Rule 33 (1)[44] of the Detention Centre rules specifies that: *'Every detention centre shall have a medical practitioner, who shall be vocationally trained as a general practitioner and a fully registered person within the meaning of the Medical Act 1983'*. Whilst this is understandable from the perspective of the provision of the primary healthcare services within the detention setting, there is an additional effect which means that only these 'medical practitioners' or GPs can provide the sub-sections of the Rule 35 reports. This case highlights that two doctors were involved in this case during the relevant period and in my view it would be helpful to consider how the GP and Psychiatric doctors interact to ensure that the Rule 35 reports are provided and whether it would be helpful to broaden the Rule to allow for the specialist colleagues involved in the care of the detained person to be able to provide the Rule 35 reports where appropriate (and taking into account the observations I have made around the training needs of doctors working in this environment). I note that in completing the Rule 35 (1) report for D801, Dr Chaudhary essentially presented the entries from SystmOne that had been made by consultant psychiatrist, Dr Belda.

- On 09 March 2017 at 15:43, Dr Belda noted within the consultation that: *'…He was*

[44] Detention Centre Rules 33 (1) - https://www.legislation.gov.uk/uksi/2001/238/article/33

referred to the LGH team once the Section 48 was completed and he was transferred to E Wing. It was thought that he would feel more comfortable in a less stimulating environment. He has been assessed by 2 staff nurses from LGH who have deemed him to be unsuitable for an inpatient admission…' and *'As his transfer to LGH has been refused by the LGH assessing team there is no longer role for the Section 48.*

Hence his Section 48 is no longer active…'. Dr Belda also advised the commencement of Sensitive/Irrelevant 5 mg on the basis that: *'I am adding* Sensitive/Irrelevant *5mg nocte to his current medication as it could enhance the effect of the* Sensitive/Irrelevant *and will help him asleep'*.

- On 09 March 2017 at 16:22, Dr Saeed Chaudhary recorded on SystmOne: *'History: called by Nurse, advised psych would like pt to start* Sensitive/Irrelevant [sic], *started now and issued. For review by psych next week'*.

- In my opinion, it is of particular note that neither Dr Belda nor Chaudhary made reference to providing a Rule 35 (1) report at this time in respect of D801's ongoing detention and the apparent decision made not to accept his transfer under Section 48 of the Mental Health Act by Langley Green Hospital.

- On 30 March 2017 at 15:42 mental health nurse Dahlia Dowd recorded on SystmOne on behalf of Dr Belda: *'History: Dr Belda. Examination: Seen at E Wing with RMN and Officer. No changes in clinical presentation from last week. Still feeling very anxious making very poor eye contact. Reporting no subjective*

changes. Today he could hardly spoke, maybe because there were 3 of us in the room. He has been see by Dr Iona Steen (no psychiatric qualifications) from Medical Justice who has stated that he suffers from a psychotic disorder. I disagree as this patient does not present with any psychotic symptoms. She has written an accurate risk assessment in terms of self-harm and suicide. He has reported nocturnal nose bleeds and the officer has encouraged him to report it to staff if it happens again. Diagnosis: Severe PTSD. Plan: [D801] *needs specific trauma therapy which cannot be provided within Brook House. I completed a section 48 transfer to Langley Green but when he was assessed by Langley Green staff deemed him to unsuitable for them. He is not fit to be at Brook House either as he cannot receive appropriate treatment. He should be released on health grounds but it depends upon the HO. His solicitor is aware of the situation'.*

- On 03 April 2017 at 09:35 Dr Saeed Chaudhary recorded on SystmOne: *'History: Patient not engaging, looking down, poor eye contact, withdrawn. Assessed and Rule 35 done for severe PTSD as per psychiatrist notes. Clinical Letter to Mr* [D801]*'.*

- The Rule 35 (1) report[45] completed by Dr Chaudhary on 03 April 2017:

    - Section 4: *'I have assessed this patient and agree with the following assessment made by psychiatrist at Brook House. He has a diagnosis of severe PTSD…'.*
    - Section 5 (i) - What impact is detention or the conditions of detention having (or likely to have) on the detainee's health and why? *'Continued*

[45] HOM028619 – D801 Rule 35 Report, 3 April 2017

deterioration in mental health without appropriate management'.

- Section 5 (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?: *'We have exhausted our resources from Brook House. Psychiatrist unable to offer further help'.*
- Section 5 (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 (i.e., in a matter of days or weeks or only if detention continued for an appreciably longer period)?: *'Possibly weeks'.*
- Section 5 (iv) - How would release from detention affect the detainee's health? What alterative care and/or treatment might be available in the community that's not available in detention?: *'Specialist PTSD treatment can be offered outside in the community'.*
- Section 5 (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 release address?: *'Not sure'.*
- Other comments: *'At the time of this report the patient is not engaging fully with myself as he is withdrawn. He has engaged with me in the past and so this may be highlighting a deterioration. The psychiatric team assessment has been completed for this patient'.*

- It is not clear what the reasons were for the time taken for the completion of the Rule 35 (1) report in regard to D801's case. The records indicate that it was known as early as 08 March 2017 that the transfer to Langley Green Hospital was not going to take place and the Rule 35 (1) report was not provided for nearly four

weeks.

- In my opinion, this case demonstrates that the Rule 35 (1) system was not operating effectively during the relevant period as a result of the apparent delay in informing the Home Office of the apparent concerns.

- Additionally, given that D801 was on an ACDT document as a result of his apparent risk of self-harm, it has not been clarified as to why a Rule 35 (2) report was not completed. In my view, a Rule 35 (2) report ought to have been considered on the basis that there was sufficient concern to have opened an ACDT.

- On 13 March 2017, Sandra Calver provided an IS.911 RA Part C which included the following: '[D801] *has had his mental health section revoked and is no longer under section 48. He remains under the psychiatrist care at Brook House or if released under the care of the community. He remains as an adult at risk level 2/3'*. I have not been provided with any other documentation in relation to this case that firstly explains how the conclusion was reached that he was considered to be an *'adult at risk'* and secondly, why it was considered that he was considered to be *'level 2/3'*. Based on the material I have been provided, in my opinion, I would agree with the determination that D801 would be considered an 'Adult at Risk' given his apparent history of *'severe torture'* and his level of risk of self-harm being significant enough to warrant an ACDT document. I am unable to locate any material that clarifies whether this information had, in fact, been relayed to the Home Office prior to 13 March 2017. Furthermore, the Adults at Risk policy does

not provide a category consistent with *'level 2/3'* and further clarification would be helpful to understand how this conclusion was reached on this occasion.

- On 19 March 2017 at 03:15, staff nurse June Watts recorded an entry in SystmOne: *'Examination: Written in retrospect. Went to give detainee his night meds at 00.30Hr and when his door was opened by staff we saw a ligiture* [sic] *around his neck which was removed by staff. Used a shoe lace which were taken from his room and plastic knives. Observations: Had a small line mark at the back if his neck but no obvious marks to the front of his neck/throat. Was sitting on the side of the bed. No obvious swelling noted. No Difficulty in breathing noted. Now on constant watch'*. In my opinion, based on my understanding of the Detention Centre Rules, this incident ought to have prompted a review by the GP in order that a Rule 35 (2) report could be provided to the Home Office. Equally, I have not been able to locate a Rule 35 (1) report in respect of D801's apparent deterioration. I can comment further upon provision of this material.

e. Whether the concern expressed at paragraph 5.57 regarding duplication and administrative burden regarding the three limbs of rule 35 could be overcome by redesigning the form to allow one report to be made under multiple limbs:

- My understanding of the Detention Centre Rules is that where the assessment of a detained person for a Rule 35 (3) report concluded that the detained person was

likely to have suffered ill-treatment or been a victim of torture then a Rule 35 (1) report ought to have been completed.

- The records provided and the cases that I studied did not make it clear that this was the procedure in place during the relevant period. The material provided has not uncovered any further explanations as to why the sub-sections of the Rule 35 process was not utilised effectively together, for example whether down to lack of a clear understanding of the processes involved or issues relating to the administrative constraints or a combination of these or other possible factors.

- From both a clinical and administrative perspective it can be seen that the way in which the three sub-sections of Rule 35 interact with each other and various other components of the system for the management of detained persons who may be suffering from mental health issues can become complex and repetitive. As outlined above, the findings on the Rule 35 (3) sub-section may require the completion of a Rule 35 (1) and/or Rule 35 (2) notification to the Home Office.

    - Episodes of self-harm and suicidal ideation ought to be managed under the ACDT process but do not appear to have resulted in the automatic reciprocal production of a Rule 35 (1) and/or Rule (2) where relevant. In my opinion and based on my understanding of the Detention Centre Rules, this ought to have been the procedure in place during the relevant period, ensuring that the Home Office were notified of the change in the detained person's circumstances. Where it is established that these mechanisms continue to be inadequately used, then in my view steps should be taken by the healthcare team to ensure that these mechanisms are used correctly

pending further review of the Rules and procedures following on from any recommendations made by this Inquiry.

- Concerns in regard to Food and Fluid refusal also do not automatically prompt the production of a Rule 35 (1) and/or Rule (2) where relevant. In my opinion and based on my understanding of the Detention Centre Rules, this ought to have been the procedure in place during the relevant period, ensuring that the Home Office were notified of the change in the detained person's circumstances. Where it is established that these mechanisms continue to be inadequately used, then in my view steps should be taken by the healthcare team to ensure that these mechanisms are used correctly pending further review of the Rules and procedures following on from any recommendations made by this Inquiry.

- Where there has been a Use of Force in order to prevent self-harm, this too does not appear to automatically prompt the production of a Rule 35 (1) and/or Rule (2) where relevant. In my opinion and based on my understanding of the Detention Centre Rules, this ought to have been the procedure in place during the relevant period, ensuring that the Home Office were notified of the change in the detained person's circumstances. Where it is established that these mechanisms continue to be inadequately used, then in my view steps should be taken by the healthcare team to ensure that these mechanisms are used correctly pending further review of the Rules and procedures following on from any recommendations made by this Inquiry.

- From the material I have been provided and the cases studied, it is my opinion that it was often the case that during the relevant period that if a detained person's welfare was being managed under one aspect of the various systems outlined above, then it was often the case that other components of the system were not triggered. I have not been able to establish a rational explanation for the inconsistency in the approach to the use of these components of the system. As indicated above, all of the various mechanisms needed to be used by the healthcare team in an integrated manner in order to ensure that an adequate approach to the welfare of the detained person has been considered and that the relevant information is escalated to the Home Office. In my opinion, work could be undertaken to consolidate and streamline these mechanisms to ensure the system is more straightforward and avoids unnecessary duplication and administrative burden.

4.3. Regarding the adequacy of the training at Brook House regarding Rule 34 and 35 (and other related matters such as the Adults at Risk Policy) generally and in particular for GPs to fulfil their role:

f. Please further consider whether the fact that there are so few rule 35(1) reports and no rule 35(2) reports during the relevant period is indicative of systemic gaps in the training of GPs and other clinicians (note, by way of example only, that the training slides at [HOM002581] hardly mention Rules 35(1) and (2) at all):

- The additional material provides limited additional evidence of the level of training provided in regard to the Rule 35. The witness statements of the management and nursing staff within the healthcare team generally acknowledged that limited training was made available and only on an ad hoc basis. Furthermore, the views provided suggested that such training would have been of primary relevance to the GPs given that they were responsible for completing the Rule 35 reports.

- The witness statements [46] [47] of Dr Husein Oozeerally did not provide any clarification or insight into the GPs understanding and utilisation of the sub-sections of Rule 35 (1), Rule 35 (2) or Rule 35 (3) with reference made only to *"Rule 35"*. I note that in paragraph 9 of his statement, Dr Oozeerally refers to *"informal training"* but has not specifically mentioned the training[48] provided by the Home Office in 2015 and whether or not he attended this.

[46] DRO000001 - BH Husein Oozeerally statement 15 12 2021 - Tracked Changes
[47] DRO000002 - BH Husein Oozeerally statement CORPORATE 25 11 2021 - 100373328_1 (1)
[48] Paragraph 5.35. of the Report dated 18 November 2021

- The Home Office witness statement of Philip Riley[49] highlighted at paragraph 59 that further training was delivered to healthcare staff on the definition of torture and the Adults at Risk policy. I note that in paragraph 60 of his statement, Mr Riley suggested that NHS England would be best placed to provide more specific detail on the training on Rule 35 of the Detention Centre Rules. In part, I disagree with Mr Riley's view on this point. I accept and agree that NHS England would be responsible for determining the service specification for the contract within Brook House, which would have included reference to the use of GPs for the provision of primary care service as well as being integral to the Rule 35 processes. However, it is my view that the responsibility for the implementation of training and the subsequent use of Rule 35 processes by the GPs would have been the responsibility of the Home Office to provide.

- It appears that where this training was provided it was only completed on a limited number of occasions and was restricted to some GPs and healthcare management staff. It appears that not all relevant staff were able to access the training either because they were on leave or for some other reason. Nonetheless, it appears that the training was not repeated or provided on a recurring basis ensuring that all members of relevant staff or any new members of staff were able to benefit from the training.

- Recurring training would have also provided an opportunity for 'best practice' to be shared and would have been helpful for improving the quality of the reports being

[49] HOM0332005 – Brook House Inquiry – Final signed statement Phil Riley

provided and the use of the appropriate Rules where indicated.

- The training materials I have been provided largely concentrate on Rule 35 (3) and did not apparently cover the other sub-sections of Rule 35 (1) and Rule 35 (2) respectively. In my opinion and based on the evidence seen through the material provided, training on Rule 35 ought to have included all three sub-sections in order to ensure the most effective use of this system and had this been provided then it is my view that there would have been better utilisation of these.

- As indicated above, the three sub-sections also interacted with other processes (ACDT, Food and Fluid refusal, Use of Force) within the detention setting and the training ought to have covered how these should be taken into account. Altogether, this could be considered a considerable programme of training that would be required to ensure that staff were appropriately guided on the use of the various mechanisms. Recurring training would be essential for ensuring that staff turnover was accounted for along with refresher training to ensure feedback on the appropriate use of the system along with updates as alterations and policy additions were made.

g. Please consider whose responsibility it is to rectify this gap in training and awareness. Consider the extent to which GPs themselves, embarking upon immigration removal centre work, should take it upon themselves to inform themselves about these Rules, and other relevant matters given their professional and regulatory duties. To what extent should this duty extend to

obtaining and reading the Detention Centre Rules, and the Adults at Risk policy? Within what timeframe might one reasonably expect a GP in a removal centre to have obtained and familiarised themselves with these requirements:

- In my opinion, the responsibility for the training in the use of the Detention Centre Rules would fall to the Home Office. In addition, I would expect the Home Office to have a mechanism for quality assessment and assurance of the reporting process in order to make sure that continuous quality improvement activities were being undertaken.

- In taking on a new role within the Immigration Removal Setting, I would have expected the GPs being asked to provide Rule 35 reports to have sought the relevant advice and training necessary for undertaking this role.

- It appears that training was not readily available and therefore, I would have expected the Home Office to have assisted in organising 1:1 training as an interim measure whilst organising wider group training.

- In paragraph 9 of his witness statement, Dr Oozeerally indicated that his training was obtained on an *"informal"* basis through his experience of working in the immigration healthcare environment. There was no indication by Dr Oozeerally that he attempted to obtain further training or that this was not available or achievable for some other reason.

- It is noted that in paragraph 12 of his witness statement that Dr Oozeerally conducts the Rule 35 training for clinicians and that this includes *"… formal description of Rule 35 and introduction to appropriate DSO and paperwork…"*.

h. What training or support is necessary to ensure that GPs maintain their independence in fulfilling their role in the rule 34 and 35 process:

- In my opinion, the current system whereby the GP is responsible for providing both the primary care as well as being responsible for the Rule 35 processes is inadequate and does not ensure there is sufficient independence in fulfilling the roles required.

- Rule 34 is inherently important for the early identification of the ongoing health needs of an individual on arrival in a place of detention and is crucial for the planning of the detained person's care whilst in Brook House or any other secure or detained setting. In my view there is no specific training requirement for the GPs for an effective Rule 34 process because as GPs they will already be trained in the screening, assessment and management of physical and mental health conditions. It is fair to say that there will be some unique aspects to the care for persons who are being detained, such as language barriers and conditions seen in other parts of the world but these factors are not unique to detention centres per se and could just as easily be found in other primary care settings.

- In terms of the Rule 35 processes, my main areas of concern in regard to independence are essentially with Rule 35 (1) and Rule 35 (3):

    - In my view, Rule 35 (2) does not require any special consideration in regard to the independence of the GPs. Rule 35 (2) essentially links closely with the ACDT process which is intended to encourage the closer working of the healthcare and custodial staff in ensuring detained persons who are at risk if self-harm and/or suicide are better supported. Rule 35 (2), in my view, is an extension from this and is intended to allow the notification of such concerns to the Home Office. My view is that this sits more comfortably from the GP's perspective as an advocate for the patient in notifying the body who is ultimately responsible for administering the detention process. In my opinion, ensuring that GPs are trained in the use of the ACDT process and linked to this, how and when to consider a Rule 35 (2) report would be triggered would be important for ensuring that they utilise these mechanisms correctly.

    - In my view, Rule 35 (1), whilst it does provide a mechanism by which the GPs can advocate on behalf of the detained persons, that continued detention is having a negative impact, it is flawed in that requires the writer to consider the *likelihood* of the impact of detention, rather than providing a view on the presenting factual circumstances at the time of writing the report. As I have already set out in my original report[50], Rule 35 (3) requires the GP to consider the likely impact of detention and in this way unhelpfully

[50] Paragraph 5.47. and Paragraph 6.2.3.6. of the Report dated 18 November 2021

links Rule 35 (1) and Rule 35 (2). I am not convinced that training alone for the GPs would be sufficient for ensuring a reliable approach to being able to being able to predict the likely impact of detention because the number of dynamic variables at play.

- In my view, Rule 35 (3) is the most challenging in terms of professional independence for the GPs. In my view and as outlined in my original report[51], this requires a level of expertise in assessing whether the detained person has been a victim of torture that is not inherently acquired as part of medical or vocational training *and* requires the writer to predict the likely impact of detention on this basis. The overbearing pressure in regard to Rule 35 (3) is the principle that where there is evidence of torture, that release from detention will follow. As I have previously explained, in my view this could adversely affect both the expectations of the detained person and the independent position of the GP leading to low levels of trust within the mechanism.

- As outlined in my original report[52], whilst the Adults at Risk Policy is helpful guidance for clinicians who may be considering those individuals who could be at heightened risk during detention, there is an unhelpful link between these risk factors and the requirement that these factors should influence whether or not someone should remain in detention or not. From an advocacy perspective, it would seem straight forward that if any of these factors were detected, then the person is likely to be at risk of harm from

[51] Paragraph 5.33. and Paragraph 6.5.1.16. of the Report dated 18 November 2021
[52] Paragraph 6.2.4.4., Paragraph 6.2.4.6. and Paragraph 6.2.4.7. of the Report dated 18 November 2021

ongoing detention and therefore should not be detained. I note that from the additional material provided, similar views are held by Freedom from Torture[53] and the Royal College of Psychiatrists[54].

- I previously outlined[55] the conflicts associated with being both the GP providing care to detained persons and the doctor undertaking the Rule 35 (3) assessments. Given the complexities involved, it is my view that training alone would not be sufficient for the proper separation of these roles, thereby ensuring there was adequate professional independence of the GPs in regard to the Rule 34 and Rule 35 processes.

i. Do you consider a GP's independence is impacted where there is a financial interest in play under the contract to provide GP services in the centre:

- I have found no evidence within the additional that there was any direct financial interest affecting the GP's independence in providing Rule 35 reports. I have not been provided with any material indicating that Rule 35 reports were commissioned or remunerated separately from the rest of the contracted service being provided within Brook House.

- The witness statements provided by the healthcare staff invariably spoke of the

[53] FFT000012 – Freedom from Torture submission to the Brook House Inquiry received 19 March 2021. Exhibit to FFT000001
[54] BHM000025 – Royal College of Psychiatrists Position Statement 07/16 on torture victims and detention December 2016
[55] Paragraph 5.40., Paragraph 5.41. and Paragraph 5.42.

considerable impact on the GP's time required to undertake a consultation for a Rule 35 (3) report. It is also possible to see that where a Rule 35 (3) report ought to have led to the requirement for a Rule 35 (1) and/or Rule 35 (2) if the rules were being followed to the letter, then this would have significantly increased the overall burden. I have not seen any evidence supporting the case that there was any personal financial interest on the part of the GPs or that this was a direct factor during the relevant period or not. However, overall, and based on the material provided, I can see that there was a competing interest between the GPs' time allocated to undertake and complete Rule 35 (3) reports and the time needed for addressing the wider physical health needs of the population in Brook House. It is possible to speculate that this may have led the GPs to rationalise the system they were being asked to use in order to save time or balance these competing demands on the time allocated to serving the overall needs of the population. This is a preliminary view until such time that I receive further documentation allowing me to comment further on this aspect of the Inquiry.

j. Are there safeguards that might be built into the contract to ensure independence and professionalism:

- In my opinion, there are three possible scenarios by which there could be enhanced provision for the safeguarding of independent advice to the Home Office.

Training in the application of the Detention Centre Rules

- The current situation remains 'as is' with the GPs providing the Rule 35 (1) and Rule 35 (3) reports: Where there is no change in the current Detention Centre Rules, the GPs would require specific training in the assessment of torture and there would need to be robust mechanisms in place for the systematic auditing of the quality of the reports and the respective decisions based on these to ensure the system was functioning as designed, if this has not already been resolved.

Amendment of the Detention Centre Rules

- The Detention Centre Rules could be altered to remove the emphasis within Rule 35 (1) in asking the GP to try to predict deterioration based on the evidence of torture. A factual account from a GP that a detained person's health *has* deteriorated as a result of detention has substantially more weight, especially where this finding is then followed by the Home Office in their consideration for some form of activity to ameliorate the deterioration, whether that be release from detention or transfer to a secure hospital or some other outcome (e.g., expedite the decision-making process for the management of detention). Additionally, the Detention Centre Rule 35 (3) would also need to be amended to remove this component from section 6. As already opined in my original report[56], the GPs are not inherently trained to assess victims of torture and specialist training would be needed.

- Where Rule 35 (3) also interacts with the Adults at Risk policy and both

[56] Paragraphs 5.33. and Paragraph 5.41 of the original report dated 18 November 2021

recognise that being a victim of torture or ill-treatment are important to consider in terms of the risk posed by detention to these people, neither completely prevent the individual who has been a victim of torture from being detained where it is determined that the immigration control considerations outweigh these risks, raising the prospect that further harm may occur should they not be released. The system in use during the relevant period appears to have placed a significant proportion of the responsibility for providing the evidence and ultimately advising the Home Office in regard to these decisions on the GPs, whereas I might have ordinarily considered that this would have been more of a matter for a Court to decide.

- In my view, it would be helpful, if possible, for the Home Office to review information relating to a person's history of being a victim or torture and/or information relevant to whether they meet the definition of an adult at risk *prior* to arriving in detention so as to make detention decisions at the outset. This could avoid inappropriate use of detention and further harm as a result.

- In my view, this aspect of the mechanism needs to be considered and resolved as a matter of priority, however, I acknowledge that it falls outside of my expertise to comment in detail as to how it could be resolved.

Provision of Independent Advisors

- One option would be to have a team of advisors in place, comprising

suitably qualified medical practitioners, working as a panel, who possess the necessary seniority and expertise in assessing and advising on cases of suspected torture to the Home Office. This solution would release the GPs working within the Immigration Removal Setting from the time-consuming and complex issues relating to the provision of Rule 35 (3) reports allowing them to focus more appropriately on the day-to-day healthcare needs of the detained persons and without the real and perceived risk of interference with their professional and clinical independence. This would mean that any identification of a possible case suspected of past ill-treatment could be referred into this separate service whether that was detected during Rule 34 screening or during the period of detention; whether by self-referral or legal representative, and could be flagged/referred to the independent assessors for their specialist assessment. In my mind, these advisors, would be similar in principle to the medical advisors that work within the Driver and Vehicle Licensing Agency. Working as Civil Servants and integrated with the Home Office team they would be able to assist in the process for assessing and considering the cases for their suitability for ongoing detention.

- An additional benefit in this scenario would be in the clinical parity between the Home Office and the healthcare provider within the Immigration Removal setting. This would help ensure that there was a mechanism by which further information could be appropriately obtained e.g., clinician-to-clinician, or feedback could be provided ensuring a better approach to quality improvement and quality assurance activities. To my mind, these independent advisors would also be responsible for the training necessary

for the practitioners and managers providing healthcare in the various settings. These advisors could also assist the Home Office in screening available information *prior* to detention, thereby introducing a mechanism to preclude the use of detention where this could reasonably be avoided.

- An alternative arrangement for the provision of independent advice would to be contract a separate service external to the Home Office. My concern with this option is that it could add an additional branch to the already complex area of decision-makers and introduces the potential for barriers around information and clinical governance, appropriate information-sharing and accountability.

- Ultimately, a combination of these suggestions may be useful to consider in order to ensure a robust, cost-effective and reasonable process is developed that provides the necessary protection for detained persons who are considered to be at risk of harm from detention. The solution needs to include vital components, such as ongoing recurrent training and quality assurance activities necessary ensuring the reliable provision of high-quality clinical information that the Home Office would need to make their decisions.

- It is understood that there have been a number of changes[57] to the Immigration Detention estate since 2017 and these factors would also need to be taken into account. For example, the establishment of a *'single independent Rule 35 team within Immigration Enforcement'*. I do not have a sufficient understanding of this

[57] HOM0332005 – Brook House Inquiry – Final signed statement Phil Riley

team and how it operates differently the mechanisms in place during the relevant period to be able to describe how my suggestions above could be adopted in line with this change.

- I note that the overall size of the immigration detention estate has also reduced since the relevant period which may have had additional benefits in terms of reducing any overcrowding which, in my view would be helpful in alleviating some of the pressure on staff.

- I am not sure whether there has been any practical response to the previous criticisms relating to the issue of there being a lack of a time limit to the period of detention, which if resolved may, in my view, be helpful in alleviating some of the detained persons' distress relating to indeterminate period of detention.

Adults at Risk Policy

4.4. Please consider the Adults at Risk Policy and statutory guidance provided. Please consider paragraph 6.2 of your report. Please provide any further conclusions on the efficacy/effectiveness of the Adult at Risk framework in light of the additional material:

4.4.1. Based on the material provided for my original report and the additional documentation provided for my supplementary report, it is my view that the Adults at Risk framework was not functioning during the relevant period as intended. I have reached this conclusion on the basis that, as opined in both my original report and in this report above, there does not seem to have been a clear and consistent use of the Detention Centre Rules, specifically Rule 35 (1), Rule 35 (2) and Rule 35 (3). Equally, and importantly, the Rule 35 (3) reports, where they were used were not completed with sufficient detail to adequately inform the Home Office of the requested information. These issues were further compounded by the fact that there did not appear to be an effective mechanism by which the Home Office could clarify or request additional information or direct the use of the appropriate report(s), depending on the circumstances in the case.

4.4.2. Ultimately, it is my view that where the use of the Adults at Risk framework was not being applied correctly, then it would have been within the responsibility of the Home Office to address these issues. That said, it appears that the department within the Home Office dealing with Brook House did not seek or were not able to remedy these issues and I have not been provided with any information that explains why this was the case during the relevant period.

4.4.3. One further observation I would like to raise is that of detained persons who were lacking mental capacity. Whilst none of the cases[58] that I studied demonstrated detained persons who were determined to lack mental capacity, it is an additional level of complexity that has not otherwise been considered and hence I felt it should be raised. Neither the Detention Centre Rules nor importantly, the Adults at Risk policy, take into account what steps should be taken in regard to those detained persons who lack mental capacity. In my view, this is an important group not to be overlooked as they, by virtue of lacking capacity, may neglect themselves with the associated risks of serious harm and death. Cases may arise from a range of acute causes of deterioration in physical and/or mental health, for example, acute psychotic episodes, acute confusional states arising from organic causes and in the advanced stages of cases of food and fluid refusal. In my view, the additional level of vulnerability in patients who lack mental capacity requires particular consideration from the perspective of both the Detention Centre Rules and Adults at Risk policy.

[58] Paragraph 6.3.5.9. of the Report dated 18 November 2021

4.5. Please comment upon whether the introduction of the requirement of detention being likely to cause harm in order to be classed as level 3 evidence under the Adults at Risk Policy re-introduces the previously removed *"whether someone with serious mental illness cannot be satisfactory managed in detention"* requirement from the previous system? Consider the cases of D149 and D1798:

4.5.1. In the Adults at Risk[59] policy extant during the relevant period, paragraph 6 states:

- *'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'.*

4.5.2. The current Adults at Risk[60] policy include a similar reference on page 5:

- [Page 5] *'There is an existing presumption in immigration policy that a person will not be detained. The adults at risk in immigration detention policy strengthens this presumption against the detention of those who are particularly vulnerable to harm in detention. However, detention may still be appropriate in an individual case when immigration control considerations outweigh the presumption of release, even for a person considered to be at risk. Although there is no statutory time limit on immigration detention in the UK, it is not lawfully possible to detain people indefinitely…'.*

[59] CJS000731 – Home Office Detention Services Order 08/2016 on Management of Adults at Risk In Immigration Detention, February 2017 v1.0.
[60] PPG000019 – Adults at Risk in Immigration Detention version 7.0, 2021

4.5.3. However, in my opinion, the current policy appears to raise the threshold for considering whether a detained person is determined to be an adult at risk by inclusion of the 'stages' in the assessment of whether they have been a victim of torture and the subsequent use of 'evidence levels' to establish the likelihood of harm resulting from ongoing detention.

4.5.4. As I have set out above, it is my view that where the current Detention Centre Rules requires the provision of Rule 35 (3) reports from the GP, this does place significant and somewhat disproportionate responsibility on the GPs to assist in providing the evidence to the Home Office that they require for making complex decisions that I might have otherwise considered would have been more appropriate for a Court to decide.

D149

4.5.5. In the case of D149, a Rule 35 (3)[61] report was completed on 27 January 2017 by a GP at Harmondsworth IRC. The SystmOne[62][63][64][65][66] records for D149 consist of a number of extracted pages rather than the continuous record and the entry relating to the provision of the Rule 35 (3) report is not contained therein. Section 6 of the Rule 35 (3) concluded:

- *His accounts of events has lead him to have flash backs of the events and*

[61] HOM020827 – Rule 35 report for detainee (D149) dated 27/1/2017
[62] DL0000135 – Medical records for D149; ranging from 2013- February 2021, Page 165/708 entries dated 24.04.2017
[63] DL0000136 – Medical records for D149; ranging from 2013- February 2021 Page 168/708 entries dated 26.04.2017-27.04.2017
[64] DL0000137 – Medical records for D149; ranging from 2013- February 2021 Page 178/708, entries dated 09.05.2017-19.05.2017
[65] DL0000138 – Medical records for D149; ranging from 2013- February 2021 Page 569/708, entry dated 01.05.2017
[66] DL0000139 – Medical records for D149; ranging from 2013- February 2021 Page 574-575/708, entries dated 19.06.2017

he has had poor sleep. I am concerned about him being tortured and would be prudent to look into his accounts in more detail.

4.5.6. I have not been provided with the Home Office response letter IS.335 in regard to the Rule 35 (3) report for D149.

4.5.7. Within the SystmOne records, there is an incomplete consultation on 19 May 2017 by nurse Manager Tanya Tande at Heathrow Immigration Removal Centre which appears to be a mental health assessment. The records provided contains page 178 of the SystmOne record but not the subsequent page. It is not clear whether the assessment by nurse Tande corresponds directly to the ACDT document[67] opened and also dated 19 May 2017. It is noted that within the "Triggers/warning" section of the ACDT document that the first item listed is "Prolonged detention". The ACDT records provided are incomplete and do not contain, for example, the daily observation records.

D1798

4.5.8. In the case of D1798, a Rule 35 (3) report was completed on 15 September 2017 by a GP at The Verne IRC. The SystmOne records for D1798[68] that I have been provided do not contain a consultation within it referring to the Rule 35 (3) assessment as the records end on 04 July 2017. The IS.335 letter[69] from the Home Office concluded:

'... it is accepted that the information provided in this Rule 35 report meets Level 2 and as such, you are regarded as an Adult at Risk under the policy. However, we are

[67] CJS001097 – ACDT Plan re D149 dated 19.5.17
[68] HOM002523 – G4S Gatwick IRCs Medical Records of D1798, dated 04/07/2017
[69] HOM014359 – Letter from Home Office to D1798, dated 18/09/2017

satisfied that your medical needs can be managed sufficiently and effectively. It is noted that the medical practitioner, in their assessment of you has not offered their opinion regarding the effect continuing detention will have on your mental health.

Therefore, when balancing the indicators of vulnerability, the negative immigration factors highlighted above, the risk of harm you pose to the public and the prospect of removal, it is considered the negative factors outweigh the risk of your continued detention in your particular circumstances. Therefore the decision has been made to maintain your detention'.

4.6. What can or might be done to avoid or address the desensitisation referred to in the report at paragraph 6.2.1.3:

4.6.1. I am not an expert in this area. In my experience within the prison estate, it is noteworthy that both security staff and healthcare staff can become desensitised over time and that this varies significantly from person to person. The rate and degree to which a staff member becomes desensitised appears to depend on a number of factors including but not limited to their age and level of maturity, relative exposure to complex matters and their own personal coping strategies. The leadership culture within the establishment also plays a key role in determining whether staff are more prone to desensitisation. A positive staff culture ensures that staff are more likely to feel that concerns will be listened to, whereas a negative staff culture stifles confidence in speaking up.

4.6.2. Amongst healthcare staff working in this area, I would expect that the process of regular supervision would help identify members of staff who may be becoming desensitised and allow for some of the emotional impact of addressing the more complex cases to be addressed in a supportive way.

4.6.3. Not all 'supervisors' may possess the necessary skills to undertake this role and within the small team working within a setting such as Brook House, it may be difficult to ensure there were sufficient staffing levels to ensure these activities were undertaken consistently and by the most appropriate member of staff.

4.6.4. I am not aware of any specific training in the area of desensitisation but if this could be located then it may be helpful for the senior management staff to undertake this training in order to better identify and address the welfare needs of the staff for whom they are responsible.

4.6.5. The 'pressure' of the environment also has an important bearing on the ability for staff to cope. In particular, staffing levels appear to be a significant factor during the relevant period. Additionally, very high levels of emergency responses, particularly in response to the increased use of psychoactive substances during the relevant period which resulted in significant diversion of the healthcare staff away from their usual duties. This would have undoubtedly been time consuming and stressful and have led to exhaustion and desensitisation. As highlighted above, a reduction in the population within the detained estate may alleviate some of this pressure on staff. In my experience in the prison setting, the incorporation of staff with additional skill sets can be helpful. For example, in some prison establishments, the healthcare team has included paramedics in the rota to

help with emergency responses. However, this is not without its own added complexities.

Food and Fluid Refusal

4.7. Please consider the relationship between food and fluid refusal and self-harm and / or deterioration in mental health of detained persons (see in particular at para 6.3.5.5). Does the system for the management of food and fluid refusal adequately address the underlying causes for food and fluid refusal by detained persons:

4.7.1. The relationship between food and /or fluid refusal and apparent deterioration in a detained person's mental health is a complex area.

4.7.2. From the case studies, witness statements and medico-legal reports, it appears that the common theme leading to a detained person's decision to commence food and/or fluid refusal within Brook House during the relevant period was their sense of frustration with the circumstances of their ongoing detention and lack of control over the final outcome in regard to release from detention or the processing of their immigration status or fear of possible deportation.

4.7.3. The witness statements provided[70] by the healthcare team provide some further insight into the challenges of the operation of the system for the management of food and/or fluid refusal. For example, it was noted that the commencement of monitoring would take place if the individual missed three consecutive meals but that the detained person could buy supplies from the shop in the interim.

[70] INQ000058 - Final Witness Statement of Jacintha Dix (Healthcare Practice Manager) in response to Rule 9 request by the Inquiry, dated 04/11/21

4.7.4. In my opinion, the system in place during the relevant period appeared to be adequate in terms of the monitoring of the health and welfare of the detained person as far reasonably possible. However, the primary focus of the monitoring that took place appears to have been in regard to the physical health of the detained person and whether there was any evidence of deterioration from this perspective but did not appear to routinely consider or address the factors contributing to the reasons for the detained person's mental health or vulnerability status.

4.7.5. Within the case study for D1527, there was an extended period of apparent food refusal which was also managed under the ACDT process. In my opinion, the material provided demonstrated a deterioration in D1527's mental health following the Rule 35 (3) report and the subsequent response from the Home Office stating that detention was being maintained. It is not clear from this case as to the reason why there was no further escalation to review or provide a Rule 35 (1) or Rule 35 (2) report to notify the Home Office of D1527's further issues following this decision. It is possible to speculate that as a consequence of the fact that where the IS.335 response from the Home Office stated that D1527 was on an open ACDT and that he was on treatment for depression that the healthcare staff felt there would be no rationale for re-presenting further information to the Home Office despite the apparent deterioration. This case highlights the concern that there was no appropriate and dynamic approach to the use of the Rule 35 system given that despite D1527's prolonged food and fluid refusal as these concerns were not relayed to the Home Office.

Relationship with Healthcare

4.8. Please consider further the nature of the relationship between healthcare and the Home Office and between healthcare and G4S during the relevant period:

4.8.1. According to the witness statements of the healthcare staff, the relationship between healthcare and the Home Office during the relevant period appears to have been variable depending on the staff position and the level of interaction. Broadly speaking and as noted above, it appears that the healthcare staff in positions of management responsibility had a relatively good working relationship with the Home Office staff, whereas some of the nursing staff described a less close working relationship. In the latter, this appears to have been in part as a result of a lack of a good understanding of their role and function, possibly exacerbated by the staff at the Home Office's demands to complete various tasks.

4.8.2. According to the witness statements of the healthcare staff, the relationship between healthcare and the G4S during the relevant period appears to have been positive overall.

Adequacy of Mental Health Provision

4.9. Please provide any further conclusions on the adequacy of mental health provision in Brook House during the relevant period:

4.9.1. The further material provided did not highlight any further areas of deficiency within the mental health service provision in Brook House during the relevant period. The witness statements[71][72] provided by the healthcare staff were useful in providing a more detailed overview of the how the mental health service operated and was accessed by detained persons during the relevant period.

4.9.2. It was noted by a number of the healthcare staff in their witness statements that there appeared to be a lack of awareness amongst custodial staff and that increased exposure to training in regard to the mental health of detained persons would have been beneficial. This is in keeping with my experiences within the prison estate.

4.9.3. In my original report, I opined that the culture in Brook House during the relevant period may have arisen as a result of inadequately trained healthcare and custodial staff. I have not located any further evidence within the additional material that assists in corroborating this view and therefore this is a preliminary view until such time that I receive further material allowing me to comment further on this aspect of the Inquiry.

[71] DWF000004 – Signed Witness Statement – Michael Wells (Senior Practice Manager at Brook House and Tinsley House), dated 05.11.2021
[72] DWF000009 – Sandra Calver (Head of Healthcare, Head of IRCSs) - signed statement, dated 09.11.2021

D687 Case Study

4.10. In relation to the D687 case study please consider Dr Galappathie's report dated 22 September 2021. Please then consider:

k. Dr Galappathie's view that Dr Oozeerally should have taken steps to ensure D687 received anti-depressants (as did occur, but only after D687 transferred to the Verne) (see Dr Galappathie at paragraph 193):

- In my opinion, it is a matter for Dr Oozeerally, the custodial staff and the nursing staff who interacted with D687 to provide a further explanation as to why he was not placed on an ACDT during his time in Brook House and in particular following the incident on 13 May 2017 following the incident where he applied a ligature immediately prior to his transfer to The Verne IRC.

- In regard to the Rule 35 (3) assessment conducted on 15 April 2017, there may be a number of possible explanations as to why Dr Oozeerally did not commence a prescription of an anti-depressant for D687 at this time. For example, it is possible to speculate that D687 did not want to be re-commenced on treatment at this time or that Dr Oozeerally was awaiting the further assessment and input of the mental health team or some other reason. I have not been able to locate anything within the additional material or in Dr Oozeerally's witness statement that explains or clarifies the reasons as to why he did not commence a prescription of an anti-depressant for D1527 on this occasion.

- It is noted from the SystmOne record[73] that the prospect of an anti-depressant was

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

raised by nurse Karen Churcher on 08 May 2017 at 16:41. However this was not apparently discussed further or raised with the GPs in Brook House following this discussion. D687 was noted to have not attended two appointments following this assessment on 10 and 11 May 2017, one of which was for the GP.

l. What Dr Galappathie says about Dr Oozeerally alerting officers to the possible need for an ACDT. Do you agree that D687 should have been managed on an ACDT:

- Based on the material provided within the available records, in my opinion there was no mandatory requirement for Dr Oozeerally to alert officers for the need for an ACDT on 15 April 2017 given that there does not appear to have been any specific thoughts or plans of self-harm and/or suicide conveyed by D687 on this occasion. In my view, it would be a matter for Dr Oozeerally to provide a further explanation as to whether or not D687 provided any further information beyond that which is recorded on SystmOne and whether or not he considered an ACDT at the time of his assessment for a Rule 35 (3) report of D687 on 15 April 2017. I have not been able to locate anything within the additional material or in Dr Oozeerally's witness statement that provides further clarification on this matter.

m. Should Dr Oozeerally have opened an ACDT himself at this stage:

- In the event that Dr Oozeerally had uncovered significant concerns during his assessment for a Rule 35 (3) report on 15 April 2017 that there was a risk of self-harm and/or suicide at the time of the consultation with D687, then in my opinion, I would have expected Dr Oozeerally to have opened an ACDT document or to have discussed with the relevant staff to facilitate this process at that time. However, based on the material provided within the available records, in my opinion there was no mandatory requirement for Dr Oozeerally to alert officers for the need for an ACDT on 15 April 2017 given that there does not appear to have been any specific thoughts or plans in of self-harm and/or suicide conveyed by D687 on this occasion.

n. Should Dr Oozeerally have written a Rule 35(2) report? If it is your view that a rule 35(2) report was not necessary at this stage please explain why:

- Rule 35 (2) of the Detention Centre Rules states: *'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'.*

- The use of Rule 35 (2) does not appear to have been broadly considered within any of the case studies I reviewed within my original report. It is not clear whether Rule 35 (2) was in use at all within Brook House during the relevant period.

- The material provided does not clearly indicate that during his assessment for a Rule 35 (3) report on 15 April 2017 that Dr Oozeerally discovered a risk of self-harm and/or suicide at the time of the consultation with D687. In the event that further information is provided to confirm that this was the case, then I would have expected Dr Oozeerally to have completed a Rule 35 (2) report on this occasion.

o. Should Dr Oozeerally have written a Rule 35(1) report? Was there sufficient consideration of whether D687 was deteriorating in detention? If it is your view that a Rule 35(1) report was not necessary at this stage, please explain why:

- The use of Rule 35 (1) in response to an apparent deterioration as a result of detention does not appear to have been commonly utilised within Brook House during the relevant period. It appears that the GPs relied on providing their assessment and views to the Home Office within the Rule 35 (3) report but as highlighted in my original report, the vast majority of Rule 35 (3) reports I reviewed specifically lacked any clear determination of *'the impact of detention'* within section 6.

- As outlined above, it is my understanding that where it was determined that there was deterioration as a result of ongoing detention that a Rule 35 (1) report ought to have been completed.

- The only interaction that Dr Oozeerally had with D687 was in regard to the provision of a Rule 35 (3) report on 15 April 2017. There does not appear to have been any specific detail recorded by Dr Oozeerally at that time indicating that there was a deterioration as a result of D687's ongoing detention. It is noted that Dr Oozeerally did not make specific reference within the Rule 35 (3) report as to whether or not ongoing detention was (or was likely) having a negative impact. In my view, it would be a matter for Dr Oozeerally to provide a further explanation as to whether or not D687 provided any further information during this assessment indicating that there was a deterioration as a result of detention. In the event that D687 did convey any information that indicated that he was deteriorating as a consequence of ongoing detention then I would have expected Dr Oozeerally to have completed a Rule 35 (1) report.

- In my opinion, the material provided does appear to indicate that D687's mental health deteriorated following the Rule 35 (3) assessment with Dr Oozeerally. I have reached this conclusion on the basis of the content of the consultations with nurse James Newlands and nurse Karen Churcher. It appears that following the consultation on 08 May 2017 with Karen Churcher, an appointment with the GP was arranged, however, D687 did not attend this appointment. In the event that D687 did attend this appointment with the GP then I would have expected the GP

to have considered writing a Rule 35 (1) report given his apparent deterioration. In the event that D687 did attend this appointment with the GP, and it was established that he had ongoing thoughts of self-harm and/or suicide, then I would have expected the GP to have completed a Rule 35 (2) report on this occasion. In my opinion, and as outlined above, I do have a concern that there does not appear to have been a consistent mechanism or approach to the follow-up and review of detained persons considered to be a victim of torture or an adult at risk where GP appointments have been missed ensuring that possible deterioration as a result of ongoing detention is monitored and detected adequately.

5. 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: **26 January 2022**

Appendix 1

Documents

Reference	Title
DRO000001	BH Husein Oozeerally statement 15 12 2021 - Tracked Changes
DRO000002	BH Husein Oozeerally statement CORPORATE 25 11 2021 - 100373328_1 (1)
DWF000009	Sandra Calver (Head of Healthcare, Head of IRCSs) - signed statement, dated 09.11.2021
INQ000051	Exhibit CT1 19.08.21.pdf - Home Office CTC Clearance letter addressed to Callum Tulley; other documents consist of his DCO Certification; Health & Safety Award & Two separate Witness Statements dated 27/08/2019 & 13/12/2019
DWF000004	Signed Witness Statement – Michael Wells (Senior Practice Manager at Brook House and Tinsley House), dated 05.11.2021
DWF000013	Signed Witness Statement – Emily Parr (Registered Nurse), dated 16.11.2021
INQ000058	Final Witness Statement of Jacintha Dix (Healthcare Practice Manager) in response to Rule 9 request by the Inquiry, dated 04/11/21
NHS000054	Witness Statement of Nicholas Watkin (Head of NHS England Health and Justice in the South East), dated 15.11.2021
NHS000039	Quarterly Contract meeting 16 March 2017
NHS000040	Quarterly Contract meeting 22 June 2017
NHS000041	Quarterly Contract meeting 31 October 2017
NHS000042	Quarterly Quality Meeting Minutes 10 January 2017

Reference	Title
NHS000043	Quarterly Quality Meeting Minutes 11 April 2017
NHS000045	Quarterly Quality Meeting Minutes 18 July 2017
NHS000047	Quarterly Quality Meeting Minutes 31 October 2017
NHS000031	Gatwick IRCs Strategic Partnership Board Meeting minutes 23 June 2017
NHS000029	Gatwick IRCs Strategic Partnership Board Meeting minutes 12 December 2017
HOM002457	Medical Records of D687 including time at Brook House, 26/10/2017
CJS003927	Rule 35 report re: D1255, dated 22 March 2017
CJS003870	G4S Gatwick IRCs Medical Records D1255, 24 April 2020
CJS000869	Rule 35 report relating to D2442, dated 11/04/2017
CJS000872	Rule 35 report - Detainee D2567, dated 13/04/2017
CJS000859	Rule 35 report - Detainee D1524, dated 25/04/2017
CJS000887	Rule 35 report - Detainee D13, dated 27/04/2017
CJS000854	Rule 35 report - Detainee D949, dated 03/08/2017
HOM0332005	Brook House Inquiry - Final signed statement Phil Riley
HOM014359	Letter from Home Office to D1798, dated 18/09/2017
FFT000012	Freedom from Torture submission to the Brook House Inquiry received 19 March 2021. Exhibit to FFT000001
BHM000025	Royal College of Psychiatrists Position Statement 07/16 on torture victims and detention December 2016
CJS001139	G4S Gatwick IRCs D687's Medical Records, 28 April 2020
HOM002523	G4S Gatwick IRCs Medical Records of D1798, dated 04/07/2017

Reference	Title
CJS000731	Home Office Detention Services Order 08/2016 on Management of Adults at Risk In Immigration Detention, February 2017 v1.0.
PPG000019	Adults at Risk in Immigration Detention version 7.0, 2021
HOM020827	Rule 35 report for detainee (D149) dated 27/1/2017
DL0000135	Medical records for D149; ranging from 2013- February 2021, Page 165/708 entries dated 24.04.2017
DL0000136	Medical records for D149; ranging from 2013- February 2021 Page 168/708 entries dated 26.04.2017-27.04.2017
DL0000137	Medical records for D149; ranging from 2013- February 2021 Page 178/708, entries dated 09.05.2017-19.05.2017
DL0000138	Medical records for D149; ranging from 2013- February 2021 Page 569/708, entry dated 01.05.2017
DL0000139	Medical records for D149; ranging from 2013- February 2021 Page 574-575/708, entries dated 19.06.2017
CJS001097	ACDT Plan re D149 dated 19.5.17
HOM032191	D801 Patient Record 31.01.17 to 03.04.2017 whilst at Gatwick IRC, Pages 6-17 of 55 only
HOM032192	Pages 19-46 of 55 of Patient Records from Gatwick IRC for D801 between 2 March 2017 and 30 March 2017
HOM028619	D801 Rule 35 Report, 3 April 2017