Brook House Inquiry

Fifth Witness Statement of Sarah Bromley

I, Sarah Bromley, of Hawker House, 5-6 Napier Court, Napier Road, Reading, RG1 8BW will say as follows:

1. I provide this statement in response to further questions raised by the Inquiry legal team by email dated 7 July 2022.

An explanation as to why it was thought that those covered by ACDT documents at the time Dr Bromley gave evidence at the Inquiry's hearing were not suitable for a Rule 35 report under either Rule 35(1) or Rule 35(2)

Further details of the outcome of the Rule 35 assessment referred to on 6 June, including whether a Rule 35(2) or a Rule 35(1) report was written and if not, why not (in relation to each limb of the rule)

2. I believe that the small numbers of patients who are on constant supervision on any one day means that individual patients are identifiable. The decision to write, or not write, a Rule 35 report is a clinical judgment based on clinical (and therefore private and confidential) information and I do not believe that it is right to disclose this level of personal data. However I am happy to comment on some of the reasons why a Rule 35 assessment may not be undertaken for patients.

Rule 35 Assessments: General Observations

3. It is arguable that detention has the potential to be injuriously detrimental to anyone's physical or mental health and therefore in theory everybody coming into a detention centre could be eligible for assessment under Rule 35(1). This would, however, be impossible with the numbers entering the centre, in part because of the sheer quantity of GP time that would be required to undertake such assessments.

4. In practice, concerns about physical and mental health are identified during reception screening and Rule 34 assessments. Our GPs make the decision to undertake an assessment

under Rule 35(1) based on the severity of their health needs and the ability of the healthcare service within the prison to meet those needs. However, as heard in evidence at the Inquiry, the GPs have found the completion of an IS91 Part C to be more effective in raising concerns and ensuring that action is taken.

5. An ACDT is a Home Office owned process that ensures a multidisciplinary response to threats of, or actual, self-harm. It is not in itself a clinical intervention but forms part of our processes to manage risk and keep people safe. It is a process that is familiar to us from our experience of the ACCT process within prisons and we know from that experience that it is important for healthcare professionals to engage meaningfully in the process.

6. An ACDT can be opened by any member of staff who is concerned and could be, for example, related to a person's response to frustration about their immigration status, resulting in punching the wall or banging their head. This is not necessarily indicative of suicidal ideation but does warrant further exploration. The clinical response that PPG have implemented to manage such situations is to ensure that anyone who is placed on an ACDT is assessed by a registered mental health practitioner to determine any suicidal intent and, should this be found, ensure onward referral to a GP for further assessment under Rule 35(2) as well as manage their clinical presentation. An ACDT may only be in place for a few hours while the team determines the wider picture and it would therefore not be appropriate for everyone placed on an ACDT to automatically be assessed under Rule 35 (2) and should that become a requirement this would place an additional significant burden on the GPs.

7. I am also told by our GPs that it is a common occurrence that when they set out to complete an assessment under Rules 35(1) and (2) they (perhaps unsurprisingly) discover a history of torture and so therefore complete a Rule 35(3) assessment instead.

8. Should there be a literal interpretation of the rules resulting in a requirement for a Rule 35(1) assessment potentially for everyone, or for a Rule 35(2) for anyone placed on an ACDT, I am concerned that this would actually increase risk. Those who are most vulnerable might be 'hidden' in such high volume activity, further increasing their risk and reducing the potential for them to be released from detention in order for their needs to be met. Should the detention rules include thresholds to help identify the most vulnerable, and therefore most appropriate to undergo assessments under Rules 35 (1) and (2), this would be helpful in

mitigating this risk whilst at the same time reducing the potentially overwhelming burden on healthcare services.

9. From the conversations we have had since September 2021, including with the healthcare teams, GPs and independent doctors working across the country in IRCs, NHSE and the Home Office, we believe have inherited a system that has not been working for many years.

10. At the time I gave evidence to the inquiry (and also during the procurement) levels of activity were low and we believed that we could resolve the issues by putting in place better processes and by close working with the Home Office and NHS England. We understand that the Home Office are planning to amalgamate the 3 forms into a single form encompassing assessment under rule 35 (1), (2) and (3), recognising that for many people all three rules could apply at once. Whilst this does not by any means resolve all the challenges of the Rule 35 processes, it may help with the confusion that arises around which rule is being applied.

11. Whilst we have continued to work with the Home Office and NHS England to support improvements in the processes, there has been a dramatic increase in the numbers at both Gatwick and Heathrow IRCs and this is anticipated to rise further. In Brook House the number of detainees arriving in one month rose from 160 in April 2022 to 374 in May, 211 in June and 331 new receptions in July 2022. With these rises in population there is a corresponding rise in the numbers of detainees requesting a R35 assessment from 15 in April to 92 in May with 84 in June and 72 in July. Not only did the actual numbers of requests rise in line with the increasing numbers arriving in detention, the percentage of residents requesting an assessment rose from 9% in April to 25%, 40% and 22% in May, June and July respectively. This perhaps reflects the numbers of detainees new to the system who had not been assessed previously under Rule 35 but this would require further analysis.

12. With the increased numbers there is a corresponding increased wait time for a Rule 35 assessment with 47% receiving an assessment within 1 day in April 2022 reduced to only 6% in July 2022. The mean waiting time has increase from 2 days in April (max wait 6 days) to 7 days in May (max wait 26 days), 14 days in June (max wait 26 days) and 9 in July (max wait 20 days). This is indicative of the pressure on the healthcare team, and the GPs in particular, working in the IRC.

13. It is anticipated that legal requests for assessment and challenges relating to these processes will likely increase further due to the Rwanda policy, as accepted by NHS England and the Home Office in our discussions on Tuesday 19 April 2022.

14. The process of undertaking Rule 35 assessments, particularly Rule 35 (3) assessments, is emotionally draining for GPs and in order to support good quality Rule 35 assessments and to support our GPs, we believe that there is a limit to the number of Rule 35 reports that can be completed by one individual within a working day, further increasing the number of GPs required to undertake this activity.

15. While increased funding may be considered by some to be a suitable intervention to reduce the waiting time for Rule 35 assessments, it is my view that this is not an adequate remedy. This is in part because of the constraints which exist within the Home Office rules. Presently, these rules require that Rule 35 reports are completed by a medical practitioner who is fully registered and vocationally trained as a general practitioner. This limits the number of clinicians who are able and available to undertake this work.

16. There is a well-recognised national shortage of GPs and, in order to manage this, we (in line with GP practices in the community) have developed models that utilise a rich skill mix of professionals to provide care. I believe that to enable senior, and appropriately trained, nurses and other professionals to support completion of Rule 35 reports would result in a reduction in the waiting time for assessment and free up GP time to provide healthcare to complex patients.

17. In addition to the pressures on staffing, there is a serious lack of physical space available for clinical activity within Brook House with only 2 clinical rooms available within healthcare. This necessarily means that time for clinical activity or for undertaking assessments under Rule 35 is limited. Even with the current numbers requiring assessment, this is putting serious pressure on this clinical space.

18. Many of the detainees arriving in IRCs are coming straight from prison. At present my understanding is that they are subject to the same rules once in detention and are usually only within the centre for a short period of time prior to deportation. In theory work to identify vulnerabilities and undertake a Rule 35 assessment could be undertaken prior to detainees being sent to the IRC, resulting in earlier identification of factors that might impact on their

deportation, thereby reducing risk, whilst at the same time reducing the pressure on the teams working within the IRC.

The number of Rule 35(1) and (2) reports when compared with the figures provided for ACDTs, constant watches, self-harm incidents and food and fluid refusals, and the extent of any disconnect between the ACDT process and Rule 35, and Food and Fluid refusal and Rule 35

19. I acknowledge that there appears to have been low numbers of assessments completed under Rules 35(1) and (2) which could appear at odds with the number of people on ACDTs and/or food and fluid refusal. However, as noted above, the behaviours that lead to use of an ACDT are not necessarily indicators of suicidality or deteriorating health. Our clinical processes ensure that people on an ACDT are assessed quickly by mental health professionals so that we can identify those that are at risk and act appropriately, both clinically and by ensuring an appropriate assessment.

20. Similarly, food and fluid refusal does not necessarily in itself indicate deteriorating health. My understanding is that most episodes of food/fluid refusal last only a few days and during that time detainees are monitored daily, in line with our food and fluid refusal policy, to check their health and observations. Should the period of food refusal extend or there be evidence of deteriorating health, a multidisciplinary discussion (including legal support if necessary) is held to determine the best course of action. Outcome from this discussion may include consideration of an assessment under Rule 35(1) or (2).

The extent to which I consider that the thresholds for completion of reports under Rules 35(1) and Rules 35(2) are too high and if so, what, if any, action PPG is taking or intends to take to address that

21. The thresholds for completion of reports under Rule 35(1) and (2) are unclear at present and, as discussed earlier, would benefit from clarification.

22. PPG have been exploring clinical pathways which integrate the Rule 34 and Rule 35 processes into clinical activity. This would mean that these rules are considered part of safeguarding activity rather than separate Home Office processes that need to be completed.

23. PPG are consulting with multiple stakeholders to understand the different perspectives on these processes and identify a way forward. These stakeholders include, to date, NHSE,

Home Office, Independent Doctors, ICIBI, GPs currently working in IRCs and Healthcare Teams.

24. This is a complex issue involving multiple components and all the stakeholders have strong views on how the process is working and what needs to happen. Any move towards integrating these processes into clinical pathways will represent transformational change in the system and will take time.

<u>An update on the Rule 35 pathway that the Inquiry understands PPG is developing and details of the outcome of the Rule 35 review</u>

25. As discussed in evidence, we have held a workshop to examine the Rule 34 and 35 processes currently in place and develop a pathway to identify points where a Rule 35 assessment might additionally be considered. The workshop included clinicians working in both IRC Gatwick and IRC Heathrow alongside managers and members of the senior national clinical team at PPG. All present agreed on the importance of identifying adults who are at risk and keeping people safe, as well as expressing a strong desire to provide high quality health services that meet the needs of our patients.

26. Our draft Rule 35 pathway reflects the discussion at the workshop that we held but I would like to emphasize that this is still a draft pathway which we are discussing with clinical colleagues and other stakeholders, including NHSE and the Home Office.

27. As a short-term measure, we have increased the number of Rule 35 appointments from 10 per week to 17 per week in Gatwick, and held a total of 14 additional GP sessions since April to support an increased number of Rule 35 assessments in Heathrow to try and address demand for these appointments. This increase is not based on meeting the demand exactly, not least because this is unpredictable, but more a recognition that more time was needed to address the rapid rise in activity. Despite these actions, there remains a backlog reflecting the increase in numbers at both Gatwick and Heathrow IRCs as noted above.

28. In addition, we held a further workshop on 3 August 2022 to consider in broader terms how to develop our healthcare services further in order to meet the needs of the population. Our pathway has been further refined as we explore how to integrate the processes into clinical pathways which meet the needs of the population and identify those at risk.

29. The workshop discussed the lack of training historically available for staff working in IRCs, including the lack of Rule 35 training. We agreed to develop a training programme for IRC healthcare staff and identified a task and finish group to develop a training offer. This work has numerous strands and aims to increase the skills of staff working in IRCs to improve identification of vulnerable patients and in particular those who have experienced torture.

30. We also discussed the training that is currently in development in partnership with the Home Office and various 3rd sector organisations The initial Rule 35 training for GPs will cover Rule 35 processes and expectations of the GP report using material developed by the Home Office, as well as training, supported by experts in the field, that explores taking a good history, identifying signs and symptoms consistent with torture, report writing and 'hints and tips' for completing Rule 35 reports. It is anticipated this training will be ready for its first pilot in autumn but I do not have a firm date yet.

31. Our clinical teams are committed to keeping our patients safe, utilising safeguarding processes that are embedded into healthcare services and well established in our secure and detained settings. As an organisation we are committed to working with all stakeholders to ensure that adults at risk and vulnerable detainees are identified and supported through the processes in place. We are keen to work closely with Home Office colleagues to review the Rule 35 requirements and processes to ensure an effective system that safeguards and protects patients, utilising a broader professional staffing group to maximise our ability to meet the demand.

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

I am willing for this statement to form part of the evidence before the Inquiry and published on the Inquiry's website.

Signed....**Signature**.....

Dated…….8 August 2022..……..