Appendix 9: Report by Dr Payne-James

ASI: SECURITY CLASSIFICATION DOWNGRADED

Re Al-Sweady Public Inquiry - 11 4 2014 – JJ Payne-James
Report for the Al-Sweady Public Inquiry

by

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at the request of

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Dated: 11th April 2014

ASI025368
Qualifications & Experience

1. I am a registered medical practitioner in independent medical practice.
2. I am a specialist in forensic & legal medicine.
3. I am a forensic physician.
4. I have provided forensic and general medical services (primary care) for the Metropolitan Police Service and formerly the City of London Police as a self-employed medical practitioner for > 20 years.
5. I have assessed approximately 1500-2500 individuals in connection with police matters each year.
6. Approximately 90% of detainees seen are male, ~20% are under 18 and ~30% have a first language that is not English.
7. One of my roles is to provide primary healthcare to detainees in police custody.
8. This may include short-term detainees in police custody, but also sometimes longer-term remanded or convicted detainees, or those detained under prevention of terrorism legislation.
9. I frequently assess and attend remand and sentenced prisoners within the prison or other custodial settings at the request of police, solicitors and others.
10. The role includes such functions as the general medical care of patients with conditions such as diabetes, high blood pressure, epilepsy and asthma and symptoms such as chest pain, abdominal pain, temperatures, diarrhoea and vomiting.
11. The role includes the assessment of many individuals with drug, alcohol (including both intoxication and withdrawal), mental health problems and with histories of self-injurious behaviour.
12. The role includes the assessment, documentation and management (including referral to specialists) of those with injury.
13. The role includes provision of primary medical care to police personnel and victims of assault.
14. The role includes assessment and provision of care to those detained under the provisions of the Terrorist Act 2000.
15. The role includes the immediate assessment of those with acute behavioural disorder of unknown cause.
16. In addition I work with a nurse team who assess, treat and triage a number of patients within this setting.
17. I am editor of the Journal of Forensic & Legal Medicine.

ASI025369
18 I was a member of the Board of the Faculty of Forensic & Legal Medicine of the Royal College of Physicians.

19 I was Vice-President (Forensic Medicine) of the Faculty from 2006-2010.

20 I am Honorary Senior Lecturer at Cameron Forensic Medical Sciences, Barts & the London School of Medicine & Dentistry.

21 I have undertaken research in various aspects of clinical forensic medicine, including healthcare of detainees, near missed in custody, assault and injury and drug and alcohol misuse.

22 I have a number of ongoing research studies related to healthcare in police custody, imaging of injury, incapacitant sprays, use of force and restraint.

23 I was a member of the Commissioner’s Advisory Panel on forensic medical issues, for the Metropolitan Police Service and resigned from that Panel in 2008.

24 I was a Lead & Specialist Assessor for the Council for the Registration of Forensic Practitioners (which ceased function on 31st March 2009).

25 I teach and lecture to doctors and healthcare workers (at all levels), police officers, gaolers and others involved in the care and management of those in police custody.

26 I have lectured to IPCC investigators on the role of the forensic physician and other healthcare professionals on the care of detainees in custody.

27 I am co-author of the Faculty of Forensic & Legal Medicine’s documents on management of head injury, medications management, irritant spray, Taser and choking in relation to police custody.

28 I have undertaken and published research in peer-reviewed publications on healthcare in custody and have undertaken collaborative research with (amongst others) the IPCC and the Metropolitan Police Service on near-misses in custody.

29 I have worked full-time in hospital in the following areas – surgery, orthopaedics, accident & emergency, gastroenterology and general medicine.

30 I qualified at the London Hospital Medical College.
I hold the following qualifications and diplomas: Bachelor of Medicine & Bachelor of Surgery; Fellow of the Royal Colleges of Surgeons of England & Fellow of the Royal College of Surgeons of Edinburgh; Fellow of the Faculty of Forensic & Legal Medicine; Fellow of the Forensic Science Society; Member of the Faculty of Pre-Hospital Care of the Royal College of Surgeons of Edinburgh; Master of Laws; Master of Science; Diploma of Forensic Medicine; Fellow of the Australasian College of Legal Medicine; European Community Specialist Certificate in Gastroenterology; on the GMC Register as a Specialist in Forensic & Legal Medicine; accredited Mediator.

I undertake a full program of continuing professional development and am appraised regularly.

I organise local audit meetings for healthcare professionals involved in detainee care.

I am external adviser to the National Crime Agency.

I was an Examiner for the Society of Apothecaries’ ‘Diploma in the Clinical & Forensic Aspects of Sexual Assault’ from 2009-2012.

I held the David Jenkins Chair of Forensic & Legal Medicine of the Faculty of Forensic & Legal Medicine in 2008-9.

I was Honorary Senior Clinical Research Fellow in the Department of Gastroenterology & Nutrition, Central Middlesex Hospital, London.


I am co-editor of the books ‘Medicolegal Essentials of Healthcare’, ‘Forensic Medicine: Clinical & Pathological Aspects’ (for which I wrote the chapter on assault and injury) and ‘Artificial Nutrition Support in Clinical Practice’.


In these I have variously written chapters on adult and child sexual assault and findings after such assault.

I am co-author of the IPCC publication ‘Near Misses in Police Custody: a collaborative study with Forensic Medical Examiners in London’.
I am Editor-in-Chief of the Encyclopedia of Forensic & Legal Medicine for which I have written chapters including those on asphyxia, carbon monoxide poisoning, assault and injury, healthcare of detainees in custody, documentation of injury, substance misuse and crime, deliberate self harm, findings after sexual assault and deaths in custody. I have just been contracted as Editor-in-Chief for the next edition.

I was a member of the Forensic Medicine Committee of the British Medical Association.

I am a delegate to the European Council for Legal Medicine.

I provide expert opinions in the criminal courts for both prosecution and defence and other bodies in a number of areas including assault and injury causation, care and death in custody.

I have submitted written or given oral evidence in all courts up to and including the Court of Appeal on behalf of the Crown Prosecution Service, defence teams, coroners, the Service Prosecuting Authority, the Independent Police Complaints Commission, courts martial and other bodies.

I have undertaken reviews of clinical care for amongst others, the Prison Ombudsman for Northern Ireland, the Prison and Probation Ombudsman and provided written and oral evidence for the Baha Mousa Inquiry.

I am a director of Forensic Healthcare Services Ltd – a company involved in the provision of expert witnesses and forensic medicine training and which has the capability of providing training for healthcare professionals working in custody.

My full Curriculum Vitae is appended (Appendix I).

Background to Report

I have been asked by Nicola Enston, Solicitor to the Al-Sweady Public Inquiry to provide evidence for the Inquiry.

I understand the full terms of the Inquiry to be ‘To investigate and report on the allegations made by the claimants in the Al-Sweady judicial review proceedings against British soldiers of (1) unlawful killing at Camp Abu Naji on 14 and 15 May 2004, and (2) the ill-treatment of five Iraqi nationals detained at Camp Abu Naji and subsequently at the divisional temporary detention facility at Shaibah Logistics Base between 14 May and 23 September 2004, taking account of the investigations which have already taken place, and to make recommendations.

With regard to my report I am given the following factual background:
During the afternoon of 14 May 2004, British military Land Rovers were travelling north along a major road in Maysan Province, Iraq (Route 6). The intended destination of the vehicles was Camp Abu Naji (CAN), a British military base.

At a location a short distance south of a permanent vehicle checkpoint (PVCP), known in the military as 'Danny Boy', the vehicles were engaged with hostile fire from small arms (such as rifles) and rocket-propelled grenades (RPG). The vehicles drove through the PVCP and reached CAN, encountering further incoming fire at different locations during the journey.

This engagement was reported by the convoy and troops deployed both from CAN in the north and Camp Condor to the south of the engagement. A prolonged armed contact resulted which occurred in two distinct geographical locations; one to the south (the southern battle) and one to the north (the northern battle) of the PVCP.

One detainee was captured at the site of the southern battle and eight detainees were captured at the site of the northern battle. The detainees were all transported in British military vehicles to CAN.

Contemporaneous documentation suggesting that they arrived in two groups on or around 20.55 and 21.55 [14 5 2004].

One by one, all nine detainees were processed shortly after their arrival at CAN.

This processing included a medical examination conducted by Corporal Shaun Carroll, a Class 1 Regimental Medical Assistant (RMA) serving with the First Battalion, Princess of Wales's Royal Regiment (1PWRR).

The detainees all remained at CAN overnight before being transported to the Divisional Temporary Detention Facility (DTDF) operated by the British military at the Shaibah logistics base near Basrah.

The detainees arrived at the DTDF on the afternoon on 15 May 2004.

On arrival, each of the detainees was medically examined by Doctor David Winfield, the Regimental Medical Officer (RMO) for the First Battalion, Royal Highland Fusiliers (1RHF).

The Inquiry has received written evidence, and heard oral evidence from Dr Winfield who oversaw and was responsible for the primary care of detainees held at the DTDF (including whilst interred in the JFIT compound). Dr Winfield's witness statement dated 23 January 2013 records that the main part of his task was to carry out part of the initial examination of detainees when they first arrived at the DTDF but that he would also attend the DTDF to assist in their sick parade.
In the light of evidence given by Dr Winfield on 12 February 2014 the Inquiry is seeking an expert report in relation to the general issues of the relevant professional medical standard that should have been applied to the conduct of the medical examinations that Dr Winfield conducted on 15 May 2004.

In this regard, the Inquiry is not aware of any written order or policy prescribing the manner in which initial medical examinations were to be conducted, although DTDF SOP NO 4, entitled, ‘Admission Procedure,’ sets out the duties of a medical officer on admission.

This was referred to during the course of the questioning of Dr Winfield.

Paragraph 13 of Dr Winfield's statement states;

'I cannot recall if I gave the medics any instructions or guidance in relation to their duties at the DTDF. It is possible that I did not give any additional instructions as their duties at the DTDF were essentially the same as their duties at 1RHF's medical centre, the only difference being that one set of patients would be soldiers and the other would be detainees.'

To assist with the background and context to these instructions, also provided are pages 328-365 of Counsel to the Inquiry's Opening statement, entitled 'Chapter 5; Medical examinations and treatment'. This provides an overview of the details of the medical team at DTDF, the initial medical examinations at DTDF, together with a background of the allegations made by each of the detainees, their examination at CAN and an overview of what was recorded.

In particular I have been asked to:

provide opinion on the appropriate professional standard that applied to the examinations conducted by Dr Winfield.

Additionally, to consider a number of issues raised during the course of Dr Winfield's evidence;

(1) Dr Winfield's evidence in relation to not asking a patient about the occasion/cause of any injury, when taking a history [144134-37; and 1441160-1]

(2) Dr Winfield's evidence in relation to not asking to see any previous medical documentation for the detainees: [144148-49];

(3) Dr Winfield's evidence that the head merits no more attention than any other part of the body (including when there are facial injuries apparent) [144183];

(4) Dr Winfield's evidence that he was justified in not noting the presence of blood under the nose of a patient, and in not wiping it away (at page 92 he states, in response to a question that [we] were not responsible for their [i.e the detainees] hygiene) [144189-92];

(5) Dr Winfield's evidence that Hamza Almalje (Detainee 090772) would have been lucky to receive the care that he did [between 15.5.04. and 24.5.04] on the NHS [1441165-6];
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80 (6) Dr Winfield’s evidence that it was right to place substantial reliance upon objective recordings, and to have regard to 'transcultural medicine', when assessing the apparent symptoms of Hamza Almalje (Detainee 090772) during this period [1441106-7];

81 (7) Dr Winfield’s evidence that there was no point in examining for a broken nose or recording blood under the nose [1441116-119; and 154-155];

82 (8) Dr Winfield’s evidence that he was justified in not referring Ibrahim Al Ismaeeli (Detainee 090774) to hospital for immediate x-ray to his wounded foot and waiting for another 16-18 hours before doing so [1441132-134].

Source Materials for the Report

83 For the purpose of producing this report I have seen or reviewed the following materials provided, accompanying my letter of instruction:

84 1) Extract from Counsel to the Inquiry’s Opening statement

85 2) [Day 144/1 - 172] Transcript of Dr Winfield’s oral evidence to the Inquiry

86 3) [Day 116/9 - 139] Transcript of Cpl Shaun Carroll’s oral evidence to the Inquiry.

87 Statements:

88 1) ASI witness statement of Dr David Winfield dated 23 January 2013 (ASI019045)

89 2) Unsigned witness statement of Dr David Winfield provided to the Royal Military Police (RMP) (SIB) dated 10 June 2004 [MOD017258]

90 3) 9 further typed RMP statements dated 11 June 2004 as follows;

91 • RMP Witness Statement - MOD012415.

92 • RMP Witness Statement - MOD012416.

93 • RMP Witness Statement - MOD012417.

94 • RMP Witness Statement - MOD012419.

95 • RMP Witness Statement - MOD012420.

96 • RMP Witness Statement - MOD012421.

97 • RMP Witness Statement - MOD012422.

98 • Draft RMP Witness Statement MOD012423

99 4) ASI witness statement of Cpl Shaun Carroll dated 29 May 2012 (ASI016052)

100 Photographs

101 1) Photographs [as print and digital best available copies] of each of the detainees taken 15 May 2004 [MOD032677]

102 2) Improved copies of PMD/1 [MOD032677 as follows;

103 • Photograph of Detainee 090772 - front MOD048732
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104  •  Photograph of Detainee 090772 - side MOD048733
105  •  Photograph of Detainee 090773 - front MOD048734
106  •  Photograph of Detainee 090773 - side MOD048735
107  •  Photograph of Detainee 090774 - front MOD048736
108  •  Photograph of Detainee 090774 - side MOD048737
109  •  Photograph of Detainee 090775 - front MOD048738
110  •  Photograph of Detainee 090775 - side MOD048739
111  •  Photograph of Detainee 090776 - front MOD048740
112  •  Photograph of Detainee 090776 - side MOD048741
113  •  Photograph of Detainee 090777 - front MOD048742
114  •  Photograph of Detainee 090777 - side MOD048743
115  •  Photograph of Detainee 090778 - front MOD048744
116  •  Photograph of Detainee 090778 - side MOD048745
117  •  Photograph of Detainee 090779 - front MOD048746
118  •  Photograph of Detainee 090779 - side MOD048747
119  •  Photograph of Detainee 090780 - front MOD048748
120  •  Photograph of Detainee 090780 - side MOD048749
121  3) Photographs of detainees labelled PMD/3a [MOD032672] taken 14 May 2004; [I am informed that the Inquiry does not have photographs from two detainees - 772 and 778]
122  4) Photographs of injuries to 775 the Inquiry understands were taken at the DTDF by the RMP on 25 May 2004:
123  •  Injury to right wrist [MOD034441 and MOD034442]
124  •  Mark on left wrist [MOD034443]
125  •  Injury to left temple [MOD034439 and MOD034440]
126  The following policy documents:
127  1) DTDF SOP NO 4 Admission Procedure: [MOD042709]
128  2) Operational Directive, Divisional Temporary Detention Facility, dated 4 April 2004 [MOD045625]
129  •  paragraph 22 b sets out the minimum standards of treatment, and includes one line on medical - "medical care is to be provided if required";
130  •  paragraph 33 sets out arrangements for medical treatment at the DTDF
131  •  appendix 2 to annex C deals with what to do in the event of an internee injury
132  •  Annex G to DTDF sets out medical related dangers at the DTDF
JFIT operational directive dated 31 May 2004 [MOD046746] (N.B the Inquiry does not have an earlier version)

- paragraph 19 - sets out minimum standards of treatment, and includes one line on medical - "medical care is to be provided if required")
- paragraph 28 - sets out arrangements for medical treatment at the DTDF, but nothing set out in relation to initial medicals;

Relevant extracts from the Daily Occurrence Book (DOB) for the Divisional Temporary Detention Facility [MOD003709]

Individual detainee records (DTDF medical records)

Not all the documents in the files are relevant to the role of Dr Winfield, but for completeness the bundle for each detainee is provided and referred to the pages dealing with their arrival and care after arrival;

DTDF Medical Record for 090772 [MOD043351 to MOD043364], including the "DTDF Initial Medical" [MOD043359-60]

Prisoner Medical Report completed at CAN by Corporal Carroll on 14 May 2004 [MOD043336]

DTDF Medical Record for 090773 [MOD043426-MOD043435], including the "DTDF Initial Medical" [MOD043434-5]

Prisoner Medical Report completed at CAN by Corporal Carroll on 14 May 2004 [MOD043411]

DTDF Medical Record for 090774 [MOD043492-MOD043512], including the "DTDF Initial Medical" [MOD043506-7]

Prisoner Medical Report completed at CAN by Corporal Carroll on 14 May 2004 [MOD043476]

DTDF Medical Record for 090775 [MOD043556-MOD043564], including the "DTDF Initial Medical" [MOD043563-4]

Prisoner Medical Report completed at CAN by Corporal Carroll on 14 May 2004 [MOD043541]
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DTDF Medical Record for 090776 [MOD043619- MOD043628], including the "DTDF Initial Medical" [MOD043627-8]

Prisoner Medical Report completed at CAN by Corporal Carroll on 14 May 2004 [MOD043604]

DTDF Medical Record for 090777 [MOD043674-MOD043682], including the "DTDF Initial Medical" [MOD043681-2]

Prisoner Medical Report completed at CAN by Corporal Carroll on 14 May 2004 [MOD043659]

DTDF Medical Record for 090778 [MOD043953-MOD043965], including the "DTDF Initial Medical" [MOD043961-2]

Prisoner Medical Report completed at CAN by Corporal Carroll on 14 May 2004 [MOD043938]

DTDF Medical Record for 090779 [MOD044014-MOD044022], including the "DTDF Initial Medical" [MOD044021-2]

Prisoner Medical Report completed at CAN by Corporal Carroll on 14 May 2004 [MOD043999]

DTDF Medical Record for 090780 [MOD044067-MOD044075], including the "DTDF Initial Medical" [MOD044074-5]

Prisoner Medical Report completed at CAN by Corporal Carroll on 14 May 2004 [MOD044052]

Additional documents referred to during the course of oral evidence:

1) Extract from Radio Operator's Log - MOD040074
2) Extract from JFIT Interrogation Report (090772) MOD040906-MOD040908
3) Extract from JFIT Interrogation Report (090772) MOD040913.

Accounts of Events

(I will only make reference to those matters which I consider relevant to my instructions).

From ‘Chapter 5: Medical examinations and treatment’ I note:
Maj Winfield was the RMO...based at 1RHFs Medical Centre at the SLB...also known as RAP...approximately 10-15 minutes walk from the DTDF...had its own medical centre

Maj Winfield oversaw, and was responsible for the primary care of detainees held at the DTDF....says that the main part of his task was to carry out part of the initial examination of detainees when they first arrived at DTDF...would also...assist in their sick parade

The medical team, headed by Maj Winfield, consisted of:

Sgt McBride...Medical Sergeant and Regimental Medical Assistant 1

Cpl Pickup...a female medic

Cpl Tough...an RMA1

Fus Davies...an RMA1

Cpl Cryans...an RMA2

Fus Rafferty.an RMA2

Cpl Dempsey...an RMA3

According to Maj Winfield the medics main duties at the DTDF were to i) take observations of the detainees before he saw them as part of their initial medical examination and ii) be the first point of contact when the detainees had any medical problem in the DTDF

Maj Winfield states that the purpose of the medical examination was to identify any physical or mental health problems so that the detainee could be treated appropriately and to assess if the detainee was medically fit enough to be detained at the DTDF

...described the medical examination consisted of two parts...first part, a medic would conduct observations on a detainee, probably with the assistance of an interpreter.....was not present at this part of the examination

After the first part of the examination, a guard would escort the detainee to Maj Winfield’s room...guards were not present in the course of his examination....An interpreter was..present....Maj Winfield would be given the ‘DTDF Initial Medical’ form in respect of a detained, partially completed by the medic who had conducted observations....He was not given ’Prisoner Medical Reports’ that has been created at CAN

Maj Winfield states that a medic...would be present during his examination of a detainee
.would, through an interpreter, ask a detainee to sit down on a chair
take a medical history
.record the detainee’s response on s2 of the DTDF Initial Medical Form (‘Medical problems including medication’)
.ask the detained to undress down to their underwear
.then conduct a three part medical examination (the results of which he would record in s6 of the DTDF Initial Medical Form), namely:
 1) Cardiovascular checks…take pulse and listen to their heart
 2) Respiratory checks…check their respiratory rate and listen to their chests
 3) Abdominal checks: with the detainee lying on their back, he would palpate the back and top of their abdomen to check that it was soft and not tender and to check that he could not feel masses and listen to bowel sounds
.would ask the detainees if had any injuries - if so would they show him, and/or he would observe them if they were obvious. He would record all of the injuries on a body diagram. He would not ask detainees how any injuries observed had been caused
.would then form a conclusion as to whether a detainee was fit for detention…as far as he can now [recall]…passed all detainees that he saw at the DTDF as fit
.Subsequent medical examination and treatment
.when a detainee had a medical issue whilst they were being detained in the DTDF…they would sometimes report it to Maj Richmond…he would then report it to Maj Winfield or a medic
.more commonly, a 1RHF would inform him or a medic that a detained had a medical issues, in which case the detainee would be seen as soon as possible if the issue was urgent or on the next sick parade if it was not
.sick parade was held in the DTDF…every morning by the medics…Maj Winfield, would usually assist
.Maj Winfield states that, on occasions, he or the medics attended the JFIT compound to see a detainee (and, on other occasions, detainees were bought straight from the JFIT compound…)
.he and the medics did not routinely check on the detainees in the JFIT compound
does not know how a detainee would raise a medical problem …while…in the JFIT compound
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204. ...when it was not possible to treat a detainee in the DTDF they were referred to
the Field Hospital for further investigation and treatment....transfer...authorised by
him and Maj Richmond.

Accounts of Healthcare Personnel

205. From the transcript of Cpl Shaun Carroll’s oral evidence I note [questions or
comments from Chairman or counsel in square parentheses]:

206. [you ran the regimental aid post at Abu Naji....your responsibilities were to deal
with when a soldier suffered from flu or needed a dressing changing or matters like
that]

207. that was routine appointments...could deal with any other injuries that came in

208. my staff would go across as well to assist in the A & E staff...depends on the
number of casualties that were coming in

209. the RAP was more like a doctor’s surgery....A & E , we were just there for routine
sick parade as well

210. [qualifications of the men working]

211. I was a senior class I medic...think the others were class 2s

212. there were doctors at the RAP

213. [broadly you saw yourselves at the RAP as a general practitioner’s surgery in civvy
street]

214. yes

215. [would you say you are essentially a first aider]

216. bit more qualified than that

217. we can prescribe, we could do basic treatments, suturing, chest drain and things like
that

218. protocol we can work by. Each class had their own protocol

219. [where would we find that]

220. in the battalion medical centre

221. sprains to colds....whatever came through the door

222. [broken wrist]

223. would go to the A & E

224. [lacerated head]

225. depends on the size...and other complications..could deal with that at the RAP

226. [gunshot wound]
depends…more likely the A & E for referral by the doctor

[MOD016729…treated two detainees]

.first time I treated a detainee

[experience of battlefield injuries]

.limited

[Events of 14 May]

[you stopped helping after dealing with one body because you were told to go and deal with the prisoners]

.yes

[medical kit consisted of a crash kit…and an ambulance]

[detainees weren’t there when you got there]

.no sir

[it was your primary role to certify whether or not they were fit for detention]

.yes

[has been suggested …your role was to certify whether or not they were fit for processing]

.no

.just the normal procedure..they would come in and they had to have a detention medical

[did you know that they would be TQ’d later]

.no

.new they would be questioned but not TQ’d

[fitness for detention and nothing more]

.yes

[who gave you your instruction about your role?]

.Captain Bailey..my RMO

[treat an enemy combatant in the same you would treat any other patient]

.yes

[patient care would come ahead of military convenience]

.yes

[can you give an example of what you mean by a ‘minor injury]

.graze or a minor laceration

[if it needed stitching..sent him off to A & E]

.yes
would escort him down. explain to the doctor

259 [in principle, a gunshot wound... refer to the doctor at A & E]

260 [similarly a large laceration to the head]

261 yes.. my own judgement

262 [err on the side of caution]

263 yes

264 [didn't send any of these detained to A & E or refer any of them to a doctor]

265 yes

266 [in your judgement you thought you could treat them]

267 yes

268 [any X-rays had to be done at Shaibah]

269 yes

270 [paragraph 41... 'On immediate arrival all prisoners are to be seen by the doctor'... Then they are seen every three hours until they leave Abu Naji.. didn't cause you any difficulty... because you had been told by Captain Bailey that it had been cleared through Brigade]

271 yes

272 [annex G to an SOI... 25 March 2004... paragraph 4... 'TQ cannot be undertaken without the internee first being examined by a suitably qualified medic... at the first practical opportunity... following must occur... a) The MO is to sign a fit for detention and questioning form... MO... that's a doctor]

273 [Al-Sweady statement... paragraph 70... and 71... you say 'I was authorised by Captain Bailey to carry out the medical examination... and complete the forms by myself... nothing... about it being authorised at Brigade level]

274 I was told by Captain Bailey... he told me by Brigade

275 [always asked... about their medical history... whether they were in pain... if they had any medical requests... always offered water]

276 yes

277 [keep any record of their answers]

278 no

279 [might had been something that would have been helpful for those who followed that there was a record of that when they were first seen]

280 yes

281 [wasn't what you were taught to do]
no

[always offered a chair]

yes

[none of these detainees was offered a chair]

that’s correct...as far as I can remember

[774...had a gunshot wound to his foot and his leg]

yes

[didn’t offer him a chair]

no

[any of them asked what they were doing out in the fields]

.can’t recall

[purpose of them being stripped was for a medical examination]

.no..purpose of them being stripped was for their clothes to be searched...and whilst they were stripped I did my medical examination]

[the stripping was for the clothes to be searched]

.and a medical examination...Captain Bailey taught me

[ever recall any resistance at all]

.no

.no recollection

[completely compliant]

yes

[if they resisted being touched, what did you do]

.none of them resisted

[was all the treatment...14 May...in the tent or back in the cells]

.most of it was done in the tent

.might’ve done one in the holding cell

[might have been naked in the tent for up to 10 or 15 minutes]

.yes

[towel or a small sheet could have been provided to protect their modesty]

.I suppose so

[interpreter..paragraph 92..she was standing in the corner]

.yes ...off to the side..behind

.couldn’t tell you where she came from

[can you see...mought have the effect of making him feel humiliated]
no sir

[should consent of the patient be obtained before the examination of him]

as soon as they stripped I took that as consent...because they were explained they were going to get searched and get a medical

[were they told that they didn’t have to take their clothes off]

I don’t know

[were they told that they didn’t have to agree to be examined]

.not as far as I’m aware

[should consent be obtained before treatment]

.they were told what was going to happen

.they were told by the interpreter

[were they told they could say ‘no’]

.I don’t know

[‘they were told that they were going to be medically examined’...might rather imply that they weren’t offered the option]

.yes

[what is the process...would last a minimum of 45 minutes]

.time they came into the tent...clothes to be searched, the medical...the sergeant major or the RSM to ask their questions and then to go back out]

[would you agree that these 9 are recorded as being in the process tent for much less]

.I can’t remember

[772.....suggests he was in the processing tent for 5 minutes]

[processing, the undressing, the redressing, the photograph must all have taken place in 5 minutes]

.that’s what it says

[773...920...and back in his cell by 923]

.I didn’t write them times...done by the guard commander

[back to 772...taken to processing at 903, your medical at 905..back in his cell at 910]

.right...I didn’t write the times...guard commander

[774...925 taken to tent...your medical at 930, back in his cell by 25 to 10]

.yes

[do you know why ..procedure was abbreviated from 45 minutes to 1 hour]

.no idea

[feel that you were under pressure]
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345    .no
346    [medical reports…one…example]
347    [your handwriting]
348    .yes
349    [column for the time of your examination…you didn’t fill that in on any of these forms…why not]
350    .I don’t know
351    [774..don’t say whether he is fit or unfit]
352    .an oversight
353    [777]
354    .same
355    [7870]
356    .same
357    [779…nil injury…don’t say whether he is fit or otherwise]
358    [one explanation…where there were recorded injuries, but you were concerned about whether or not they were fit for detention you decided that it was better not to say…]
359    .no…oversight
360    .was under no pressure
361    [were you concerned about being complicit in the tactical questioning]
362    .no sir
363    [paragraph 96..’I completed a prisoner medical report in relation to each detainee. I recorded the detainee’s name and date of birth…note of any visible injuries and any relevant details about a detainee’s medical history’…on none of the forms for these nine is there any reference to a medical history]
364    .if they would have said to me that they had diabetes, epilepsy or something with the heart or asthma, I would have recorded it; anything else…didn’t record because it was nothing relevant
365    [what is relevant]
366    .things like asthma, diabetes, heart murmurs, psychiatric, that sort of thing
367    [did you ask them]
368    [didn’t ask about any particular things]
369    .would go through like a list
370    [and because they didn’t say ‘yes’ you didn’t record anything]
that’s right

[you fill in the forms…as soon as you could after carrying out the examination]

yes

[penultimate paragraph]

’I do not recall any of the detainees telling me how they obtained their injuries…just assumed…due to being involved in the earlier firefight]

[why didn’t you ask them]

wasn’t part of my job

[why didn’t you ask these men]

I don’t know

[medical examination could can’t have lasted more than a minute]

.correct…visual check

’large laceration to [left] hand. Wound to upper [left] leg. Bloody nose…’ …..what is to the right of bloody nose’

.nil..means …wasn’t broken or anything..just blood

[why didn’t you record dimensions of the laceration]

oversight

[consider the possibility of concussion]

.yes…check his pupils with a pen-light

[why don’t you record ‘no evidence of concussion’]

don’t know

[MOD048732….photograph…arrival at Al Shaibah….looks as though…bruising on his left cheek…bridge of his nose]

.no

[abrasion above his left eye]

.no. All I can see is dirt

[statement of Mr Winfield…‘[unkempt]…two superficial abrasions on left thigh, some on left and right shoulder and one above his left eye. There was also swelling and bruising over his left cheek, the bridge of his nose and his right eye’..you didn’t record those injuries at Abu Naji]

.didn’t see them

[if you had seen them, would you have recorded them]

.yes
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398   [must it follow that when you examined him, he did not have the injuries which Mr Winfield describes]

399   .they could have come out after….bruising takes time to appear…superficial lacerations could have been the dirt…could have missed them

400   [if you treat a man’s wounds would you expect to record that]

401   .yes

402   [why don’t you record the application of dressings on the medical report]

403   .I don’t know

404   [773…date of birth 1986…did you make any allowance for his age when you certified him]

405   .no

406   [773…right arm hanging down…soldier seems to be holding his identification card…why]

407   .no idea

408   [774…another medical which must have lasted a minute or so]

409   .yes

410   [medical report..‘injury to the right foot….gunshot wound’]

411   .cleaned …no exit

412   [‘gunshot wound right leg’]

413   .yes

414   [‘lateral aspect, knee wound cleaned, dressed, graze’]

415   [‘gunshot wound upper right thigh’]

416   [‘cleaned, dressed, graze’]

417   .no I was making sure that there was no penetrating…more like a track across the skin

418   [think that there might be a bullet lodged inside]

419   .not at all

420   [risk of infection]

421   .no..because I cleaned the wound

422   [medical report and there is only a mention of two grazes]

423   .not three

424   [if your notes are to go by, there were two grazes and one further injury which was not a graze]

425   [consider referring him to a doctor]
[at Shaibah. 16 May...’emergency admission via A & E with gunshot wound to right foot....20 year old...admitted ...shrapnel...right foot and right...knee’..reference to shrapnel being removed]

[at the time they were not that serious

.I didn’t know at the time

.didn’t think he warranted it

[you missed it]

.yes sir

[at 2.21 Private Shotton gave him some painkillers and anti-inflammatories]  

.yes sir

[why wasn’t he given those drugs earlier]

.he wasn’t in pain

[is there a coincidence between food and painkillers only being given after the questioning was over]

.I don’t know. Not in my opinion

.he wasn’t in discomfort at midnight

[an alternative construction is that you knew from 930 that he would need painkillers but you wanted the questioning out of the way before he was allowed to have them]

.no...against patient protocol

[paragraph 15..your Al-Sweady statement...’..gunshot wounds would normally be treated by medics on the ground and/or taken to A & E...774 had gunshot wounds]

.they were not gunshot wounds in my opinion

[another medical that lasted a minute]

.that’s right

[’small laceration to left side of face in eye line, wound glued’..did you dress that]

.would have done sir

[why don’t you record having dressed it...oversight]

.yes sir

[pressure]

.no

[776..’fit, nil injury’....Shaibah medical reports....sketch ‘superficial abrasions’...might you have missed that]
Re Al-Sweady Public Inquiry - 11 4 2014 - JJ Payne-James

454  yes
455  .if I had seen it I would have recorded it
456  [778…another medical examination lasting a minute]
457  .yes
458  [nil injury….Shaibah…‘superficial abrasion both elbows – lower arms, small graze on back]
459  .that would have been so superficial – I wouldn’t have recorded them
460  [if you had seen them]
461  .yes
462  [assume that you didn’t see them]
463  .yes
464  [779…photograph..6 do you think we can make out beneath his mouth, some blood]
465  .no
466  [you describe…No injury…Al Shaibah…‘bruising, swelling on cheek’ and ‘superficial [something] on other side of face’]
467  .bruising and swelling takes time to come out
468  .he cleaned his face so I could specifically check
469  [sure…he did not have those injuries]
470  .not 100% sure
471  [780..medical lasting a minute….you removed shrapnel]
472  [medical report…‘small piece…shrapnel…removed from right side of face]
473  .left
474  [‘just in front of ear…graize to…left side of face around eye’….how did you removed the shrapnel]
475  .forceps
476  .they were told I was going to take it out and dress it
477  [772…had a large laceration to his head…you weren’t worried about that]
478  .No
479  [what did Mr Bailey say about stripping for the purposes of a medical examination]
480  .I can’t remember
481  [he…told the Inquiry that there was no medical justification for these prisoners to be stripped naked]
482  .I could have done my medical while they are in their underwear
483  [Inquiry statement [AD1016083].paragrapj 141…’I do not recall examining the detainees on 14-15 May]
484  .can remember a couple of things
485  [774…walked with difficulty]
486  .no he didn’t
487  [taken to FHT for TQing….brought back to his cell at 216….five minutes later…first record of a painkiller…what is your explanation]
488  .I can’t explain
489  [you were asked about questions of consent to medical treatment…before…did you explain through the interpreter what you were intending to do]
490  .yes told I told him I was going to check the body
491  [any of the detainees indicate they didn’t want that to happen]
492  .no
493  [would you ask a British soldier to sign a consent form]
494  .no
495  [explicitly ask them whether they consented to you giving them painkillers or dressing a wound]
496  .no
497  [would you take it from the absence of resistance and following and explanation that they agreed to the process]
498  .yes
499  [wound to the foot..did you think there was a bullet or shrapnel or a pellet lodged in the foot]
500  .not at all
501  [another part of the records from Shaibah…’right foot, overlying swelling and tenderness, no obvious entry wound’]
502  .exactly what I saw
503  [772…you have recorded a large laceration….Shaibah…two injuries marked to the head..’small abrasion above left eye’…’swelling and bruising to the left cheek, bridge of nose and right eye’. No mention of any large lacerations…any reason why that might be]
504  .no idea
505  [possible…on cleaning and dressing…turned out not to be quite as large]
506  .yes
David Winfield states:

[10 6 2004]

the examination at DTDF is in two parts

initially a medic will carry out a standard set of observations including weight, blood pressure, temperature, urine analysis and blood glucose

following this I would conduct a full examination to identify any medical problems and whether they are taking medication or not

after this I carry out a cardiovascular, respiratory and abdominal examination to determine whether they are fit for detention

all of the information is recorded on a DTDF Initial Medical Form

on this form I would also note any injuries that the internee had

all medical history of the internee is recorded on a FMEd965 and held on file at the DTDF

all noted made regarding check ups, examinations and medical complaints are entered into FMEd965

at the DTDF internees can report any medical problems by informing a guard.

From the transcript of Dr David Winfield’s oral evidence I note [questions or comments from Chairman or counsel in square parentheses]:

[witness statement…23 January 2013]

[GP…BMedSci…MRCGP]

[April and July 2004…based at Shaibah Logistics Base]

[major and the regimental medical officer]

[provision of medical care to soldiers…primary care service]

[secondary function….provision of primary care to those detainees that were detained within the DTDF]

.DTDF took up more time than the soldiers

two different medical centres…one for detainees within the DTDF and one at the regimental aid post for soldiers

[[MOD045634]..paragraph 33….operational directive…concerns medical arrangements for detainees and for the guard force]

[‘a five bed medical facility…within DTDF….for the treatment of detainees’]

cannot recall if it was 5

[people were either kept in the compound in the DTDF or the JFIT on the one hand or were sent off to the field hospital on the other]

.broadly speaking
[cases of serious or specialist illness or injuries amongst internees may necessitate treatment in role 3 medical facilities]

that’s the hospital

[detainee’s medical records would be kept in filing cabinets within the medical facility within the DTDF]

[would you expect the medic to be called if a detainee in the JFIT needed to see a medic]

[in total, the complement of staff was eight…and you led them]

[did you give any particular instructions or guidance to those seven staff as to the system was to work within the DTDF medical facility]

.can’t recall giving any specific guidance

[any particular instructions]

.no more than normal

[what was normal]

.back in Cyprus…daily basis…with the exception they’re not detainees…business as normal

[any guidance or instructions as to the differences that the new situation might present]

.I’m confident I would have spoken to them…can’t recall the specifics

.similar to…what…Major Richmond, would have done…sensitivities of the situation, the sensitivities of dealing with the detainees, the need to be scrupulous, be careful with documentation, to have a low threshold for discussing cases with me if they were worried

.mindful of the difficulties of translation, of working through interpreters…if they had concerns…to speak to me directly

[detainees rather than soldiers. How did that affect the approach to be taken]

.not sure it fundamentally did change the approach we had…treat individuals on the basis of clinical need and clinical requirement

[principle that detainees should receive the same quality of treatment as a soldier or any other patient]

.absolutely

.principle of the Geneva convention
554 [was acted upon at all times]
555 .I believe so
556 [any specific training in relation to your duties as a RMO in relation to the provision of medical care to detainees]
557 [first army-specific medical training that you underwent was PGMP course]
558 .yes
559 [very little medical training in that]
560 [second part, there wasn’t anything focuses, was there, on the treatment of detainees]
561 .don’t recall anything specific
562 [training include any reference to those parts of the Geneva Convention that are specifically relevant to medical officers]
563 .can’t recall
564 .know during my military career …have had training on the Geneva Convention and how treatment is given on clinical needs rather than…on which side the combatants are on
565 [paragraph 34…statement….do not recall from your military of your medical training…any training on the medical treatment of detainees]
566 .I think that’s correct
567 [and..’prior to my tour, the only medical care I had provided to persons in detention was to the British forces soldiers…referred to above]
568 .that’s correct
569 [these are SOPs issued by Major Richmond…Can you recall whether you saw these]
570 .can’t recall
571 [para 2..‘if the internee has any visible signs of injury or appears to be in particularly poor health or is complaining of pain, then he/she must be seen by the DTF MO as soon as possible and deemed fit for detention. If unfit for detention and the MO has advised hospitalisation, then the MPS Day Officer must be informed as soon as possible regardless of day or night. Was that the system that was in place]
572 .essentially, yes
573 [wasn’t it in fact, the case that all internees had a medical examination by you irrespective of whether they were in particularly poor health or complaining of pain]
574 .yes
575 [any obligation as to when]
576 .I was under the impression it was within 24 hours
577. in reality it happened almost as soon as they came in
578. [you say that you effectively relied on the forms that had been printed up and
provided to you as to the nature of the task you were required to undertake]
579. yes
580. [was there an overarching policy dealing with specifically with care to be provided
to detainees by army medics and doctors]
581. .other than the Geneva Convention, not that I was aware of
582. [never certified any detainees as either fit or unfit for interrogation]
583. .no
584. [would you agree that without a detailed knowledge of the process that the detainee
is to undergo you will be unable properly to assess the implications of detention on
an individual]
585. .not sure that I would agree with that…most of us would be able to anticipate what
detention would be…in terms of a medical opinion…think that would have to be a
medical person
586. .don’t think I would have known the details of interrogation techniques
587. .decision on whether they were fit for detention was..was there any physical or
mental issues that meant they wouldn’t be – or that they really need transfer to
hospital
588. [if..detention involved interrogation]
589. .I think it would influence the decision
590. [mild form of mental illness]
591. .you would take it into account..difficult to identify a minor mental health problem
592. [what would you say to the proposition that a doctor should have no involvement at
all in a decision on fitness for detention; a medical officer’s role is to identify a
medical issue and not to comment on detention at all]
593. .not sure I know the answer to it
594. [your view on whether a medical officer’s role is restricted to identifying medical
issues and treating them, rather than lending themselves to the custodial process and
making a decision on fitness for detention that has the consequence of permitting
someone to be interrogated…..Whose responsibility was it to decide whether a
detainee was fit to be interrogated]
595. .think that fell under the remit of fitness for detention
596. [what kind of injury or condition would render a detainee unfit for detention]
injury or condition that required them to transferred to hospital...huge amount of injuries. There’s an acute medical emergency, an acute surgical emergency...list is endless]

[would you habitually ask if a detainee was in pain, in those terms, as part of your medical examination]

.believe I would

.it’s part of history-taking

[important to frame that question in as simple and direct manner as possible]

.yes

[‘are you in pain’]

.would have asked that as well

.could have asked both

.would normally treat the pain, or identify the case and treat

[would you ask the detainee what the cause of pain was]

.it depends

[wouldn’t it be a normal question to ask the detainee’s subjective view as to the cause of the pain]

.not necessarily, no

[would you ask...what the cause of any injury was]

.I recall...made almost a conscious decision not to enquire about the background ...to their injuries, because...I felt I wanted to stay medically separate and not feel I was part of the..questioning

[wouldn’t you agree ...could assist the doctor in diagnosis]

.in some circumstances, yes

.not sure I would specifically ask unless the information was volunteered

[would ask a soldier...had caused their pain or injury]

.not specifically, I think with an injury you would ask about an injury, yes. But..if they came in saying ‘I have a headache’ you wouldn’t say ‘what’s caused that headache’]

[If somebody said ‘I have a pain in my knee’...You would just stay silent]

.no, you would in those circumstances

[why wouldn’t you pursue the cause of an injury with a detainee]

.I am not sure
[did the detainee’s age affect your assessment as to their fitness for detention]

.not that I recall

[in each of the first set of RMP statements...describe...detainee being examined by you within the first 24 hours of admission, Was that because you weren’t able to give a time of examination]

.can’t recall

[why was it that you didn’t record the time of examination]

.can’t recall

.I think I examined every detained who came in and it was well within the 24 hours, almost as soon as they arrived

[you say ‘the internee needs to be accompanied by documentation to this effect. It this isn’t with him, or if he had been examined by a foreign doctor a medical examination is always carried out’]

.I’m not aware of any medical documents coming...I wasn’t aware of any medical paperwork

[you didn’t receive the previous medical records]

.don’t recall getting them

[what about if a prisoner arrived with a dressing to a wound.....wouldn’t you expect to see some documentation]

.don’t recall that happening

.I am not sure it would have made a huge difference....having seen the CAN documents

[I think you know it’s the case that the Camp Abu Naji documents in general terms record some injuries that you did not]

.yes

[but might they not have fulfilled at least that limited function...namely...medical record ...says ‘large laceration to the left side of the head’ you might think..’...I’ll have a look at the left side of his head’]

.agree that would have been very helpful

[not provided with Corporal Carroll’s prisoner medical reports]

.don’t recall seeing them at all until I received them for this inquiry

[did you not seen any signs of previous medical treatment on the detainees]

.can’t recall
[anything stopping you or a medic attending the JFIT perhaps regularly, daily as a matter of routine]

.wouldn’t have been a reason why…I couldn’t go in there

[were there a reason for not carrying out a sick parade]

.think it was down to the detainees to raise medical problems with us

[if you had seen an injury on initial examination…would you ever…enter the JFIT and check up on that detainee]

.depend on the circumstances

[what about somebody that had maybe two gunshot wounds and a shrapnel injury to the lower body]

.remember examining the patient and they appears to me very minor wounds

.just very pleased I did send them to hospital the next day…they appeared fairly superficial and fairly insignificant

[I think it is right you have no separate recollection of each individual detainee]

.broadly speaking

.think I would struggle to distinguish between the nine of what I did during the examination

.recall the details of that wound on the right leg

[was your method first to ask the detainee first whether they had any injuries…so two parts of it..one asking them if they had any injuries and another part examining them to see if they had any injuries]

[if the detainee said that they had any injuries, would you immediately examine those]

.or document it

[physical examination]

.speak to them first

.do a basic medical examination of their chest, their respiratory, their respiratory cardiovascular system, their abdomen

.then would document..what I saw and found

[you said you would speak to them first]

.would have been asking…whether there was any previous medical problems, whether they had an allergies, whether there was any sort of ongoing medical problems

[whether they were in any pain]
667 may have asked that
668 [any injuries]
669 .that did come later on
670 [if a patient didn’t mention an injury in a particular area of their body, that wouldn’t be a reason for not examining it]
671 .wouldn’t examine something that didn’t need examining
672 [would you be taking your key from your patient, or would you conduct a full top to toe examination irrespective of what the patient said as to pain or injury]
673 .think what I recorded was injuries that were obvious to me
674 .or apparent to me
675 .injuries that the detainee raised with me
676 .fair to say I didn’t do a top to toe, inch by inch full body forensic examination
677 [wouldn’t look at his leg if he didn’t tell me he had a leg injury]
678 .majority…visual inspection
679 .would have taken their top off and then they would have taken their bottoms off
680 .would have had underwear on
681 [both…removed at the same time, but with underwear on]
682 .cannot recall
683 [conducted with them on the couch]
684 .would get them to stand up, turn around and look at their back
685 [visual inspection was carried out with them on the couch or standing up]
686 .think it is both
687 [visual inspection is going on all the time]
688 .palpate his tummy
689 .ask if he had any injuries on his legs
690 [how did you compile your notes]
691 .suspect I would have written down as I went along
692 [directly to the form we have seen]
693 .I believe they went straight on to the form
694 .believe the body diagram is on the other side
695 [if you saw an injury, you would write it down]
696 .would endeavour to
697 [irrespective of severity]
698 .I don’t think I can say that
my take on a full forensic examination would you be, you know, photographs…every injury measured, photographed, recorded

think this was a fairly rough and ready overview of the physical condition of the detainees when they arrived

[you would record all of the injuries that you saw on the form]

[so why did you adopt the practice of only recording obvious and significant injuries]

I’m not sure I can say why I did that.

[body diagram…of detainee 775]

[you have recorded ‘very superficial abrasions’…left scapula…are very superficial abrasions obvious and significant injuries]

.if he had raised it to me I would have documented it

[so should the qualification that we have introduced itself be the subject of qualification, namely ‘unless the detainee raised the injury with me, in which case I would note it down even if it wasn’t obvious and significant]

[ever take any photographs of injuries]

.no

[772 – Hamzah Almalje …cut to the head and upper left thigh…2137..dressings applied…two hours or so arrival at your place….received at the DTDF at 1430…guard at Camp Abu Naji…saw a large wound to the head..poured water over it to get rid of flies…any doubt …there was a large laceration]

[any explanation]
.one is that the one of the injuries I have noted there is what they said was a laceration...if it was in the hairline...had been cleaned and dressed...can’t see that small abrasions above the left eye would equal a large laceration.

.if there had been a dressing there, I would have looked under it.

[MOD048732.....photograph...part of the reception processing]

.quality of photo...left cheek..bridge of his nose appears swelling

[small abrasion above the left eye]

can’t see that on the photo

can see there’s some redness just below the left eye

.possibly some swelling of the cheek

[swelling and bruising on the right eye]

.looks like have shaded sort of the inner..inner aspect of the right eye

.think I can see that within the quality of the photo

.if it was blood, what would you have done

.probably not a huge amount

.looks like it has come from the nose

.which has got bruising and swelling

[Corporal Carroll...recorded this as being blood]

.any reason you didn’t record the same

.not sure there would have been a requirement to draw blood

.would it be important to show that it is not just a swollen nose...but the fact that it has bled]

.not clinically significant no

.did you clean up his face

can’t recall

.one of my medics might have

.may have cleaned himself up

[interrogator...detainee was particularly smelly and dirty..dried blood covering his face]

[tend to suggest he was not cleaned up]

[would that be part of the normal process, medical examination and treatment, not to clean up the consequences of injuries that detainee had suffered. To leave them smelly, dirty, covered in blood and dirt]

.we weren’t responsible for their hygiene
when it was clinically indicated, as we saw with wounds were cleaned and dressed
dressed

can’t recall the specifics

if they were showing signs of difficulty communicating or signs of clinical shock…think I would have noted that

[record of interrogation…..internee appeared to be in great pain and unable to stay upright…still looked concussed…as time wore on he became more confused…16 May]

think I would have recorded it

due to his injuries he appears to be confused and unable to maintain a straightforward conversation]

[record of interrogation on 21 May…..’appeared to be in pain and unable to stay upright for too long…difficult to understand’…were you informed]

not that I recall

I think if the interrogator or the guards had concerns about him, he would have been seen by the medic again

if a medic notes an injury to a detainee after reception…would it be their duty to make a note of it on the reception form]

not necessarily

where would they be required to make a note]

put it as a new entry…on the medical record

[vomiting one of the symptoms of concussion]

can be a sign of significant head injury

[loss of appetite]

can be

[remaining entries about the condition of this patient between 16 and 24 May]
[Corporal Cryans..stomach pain...called to see JFIT to see..about the above problem....had this for three days...On examination...complains of stomach pain...lying back with his feet up smiling...hasn’t ate since being detained here..wouldn’t tell the interpreter anything about his symptoms...Rx....advised on [eating]/drinking...review in a day if no better.....Next entry....vomiting and stomach pain...Called to JFIT as interpreters saw him vomit blood...doesn’t look particularly unwell..36.9..134/74..74 ..oxygen saturation 100%....Very small amount of blood mixed with saliva on walkway..various puddles of bile seen....18/05...patient has been vomiting all day, not ate...advise from RMO]

..Stemetil injections

[18 May..JFIT..detainee had vomited and urinated over himself in a cell..not been to toilet for 24 hours....Refusing to eat as it makes him ill. Guards and JFIT interpreter brought detainee..RMO already here]

..probably says ‘looks ill’

[pain in...umbilical area...18 gauge cannula]

..antecubital fossa...Hartmanns solution up and running through....reassurance , 15 minutes obs

[your entry]

..conflicting story – guard says he has vomited x 1 and isn’t eating...bowels not open since yesterday

..says vomiting profusely hasn’t eaten for 6 days (makes him feel ill)

..denies any diarrhoea, normally fit and well, tolerating water, no previous medical problems

..slightly dehydrated....apyrexial....stated what his blood pressure, pulse and oxygen saturations are....his blood sugra..listened to his chest and his tummy

..abdomen soft, no obvious tenderness, no masses, bowel sounds present

..my impression was mild dehydration and the plan was for IV access and fluids

..monitor progress. Felt improved discharged back to JFIT..review SOS

[21 May...sore head, stomach and back....called to JFIT.initially said was passing blood in stools then changed mind...has pain in stomach...still not eating...not drinking much water..advised that he cannot receive medication on empty stomach....also advised on fluid intake]

[16 May during the day...before 1805...RMA2..have advised a reference to you. Then you haven’t examined the patient]
.it doesn’t appear I have
[why not]
can’t recall…suspect that Corporal Cryans would have spoken to me…would have had a discussion…would have given me all his observations he gave over the phone….would have asked whether he wanted me to see him…made a judgement
[no entry…17 May..do you think this is a man that should have been followed up on 17 May]
I think so with the benefit of hindsight
[think this man ..should have been seen or at least monitored by a medic]
.not sure he needs to see a doctor…..the clinical situation did improve…was being monitored by the guards]
[would you have treated a British soldier in the same way]
.I believe so
[weren’t told……anything that the JFIT interrogator had seen]
.not that I’m aware of
[wold that have made a significant difference]
.not sure I can answer that…found quite a lot of the detainees…prone to exaggerate or ham up their symptoms….medics would rely…using objective measure]
[did that affect the way you treated all detainees]
.I think it was what we would call transcultural medicine
.have to rely much more on clinical observations, rather than the sometimes dramatic appearance of a detainee
[what does transcultural medicine mean]
.how different cultures treat medical complaints..differences between presentations between different culture
[agree that the history of vomiting blood is serious]
.depends on the context
[history…came from the JFIT interpreters]
.yes
[22 May….your entry…the second half of it…from ‘on examination’]
.yes
[complaining of headache stomach pain…carried into ..centre after collapsed. Hasn’t vomited. Says he’s eating and drinking, but guard says he’s not]
[On examination…by you]
.says ‘bright and alert’

.II-XII intact. Abdo soft, non-tender, no neck stiffness…tone, power. Reflexes…all stable…Plan…advise food and fluids…Nil abnormal to find

.couldn’t clinically find anything wrong with him

[next day, 23 May…complaining of headache and vomiting.’Called to cell by guards. At that time could only walk with help, wouldn’t get up under [own] steam, however managed to walk to medical centre’]

.managed to walk to…centre okay

.says he is constantly vomiting with severe headaches. Speech is slow but okay under the right questions (ie do you want tablets) he looks lethargic and is constantly trying to lie down…then talks about the blood pressure, pulse and oxygen stats, talks about his temperature…Advised from RMO Stemetil and Co-codamol..to be put into a JFIT cell for close observation, patient is happy with this’

[what does to be put into a JFIT for close observation mean]

.would have suspected that it would have been back into the cell and the guards to keep a closer watch on him….probably more frequent that usual

[24 May…complaining of headaches…’called to JFOT, as above consultation, third time…headache, guards kept observation throughout the night, patient slept, no vomiting…looks considerably better…a lot more alert….headache..possibly to not taking fluids…says medication made him feel better…co-codamol]

.total of eight over [24] hours..advised on fluids and removed from observation

[would you say the detainee was fit or unfit to be interrogated on 16 May]

.based on the clinical observations….retrospectively…would probably say he was fit …on the history ..suggest he was probably unfit for interrogation

.would probably say unfit

[by the 21 May]

.based on that we couldn’t find anything exact, then I would say he was fit for interrogation

[series of the medical forms…772..773..774..775..776, 777, 778, 779…all 1 July…780…11 December]

[was there a practice of recording…1 July]

.had not noticed that before

[773…just short of 18…would that have affected your conduct in any way]
Re Al-Sweady Public Inquiry - 11 4 2014 – JJ Payne-James

827  no

828  [only injury you record…slight bruising and swelling of nose…..Photograph….some redness along the left side of the nose]

829  not that I would comment on…

830  [MOD048734]…any dark red at the bottom of the nose

831  possibly with the eye of faith and you telling me

832  [if we go back to the processing photo at Camp Abu Naji MOD032673….do you see an apparent mark on his left cheek at the level of his mouth]

833  possibly I can see a mark

834  [do you know why you haven’t recorded it]

835  no

836  [is bruising and swelling of the nose a symptom of among other things, a broken nose]

837  it’s not something you can clinically check for…not even an X-ray

838  [how is it confirmed]

839  [do you think this man had got a broken nose]

840  clinically, no

841  don’t routinely x-ray a broke nose

842  would’t normally write down ‘no fracture’..because it is not something you can confirm or refute

843  [774..Corporal Carroll…day before your examination…first an injury to the right foot, a gunshot wound, cleaned, no exit and dressed….second injury….right leg..lateral aspect of the knee..wound, cleaned, dressed….graze…thirdly, a gunshot wound to the upper right thigh which he’s cleaned and dressed ..also has the word graze written after it]

844  appears fair

845  [know…given some co-codamol and diclofenac…221…]

846  looks like one time diclofenac sodium…medium dose painkiller..‘treat gunshot grazes to the right leg and foot

847  [we assume…medics at CAN assessed it was necessary for these wounds to be treated with…moderately-dosed painkiller and an anti-inflammatory….and …a gunshot wound to the foot would be painful]

848  you would anticipate it

849  [think you recorded this man as limping….agree….earlier medication…worn off]
I don’t recall…would hope I would have

(...)injury to the right foot…’overlying swelling and tenderness’

...gesture or expression of pain...you would equate to tenderness

yes

[didn’t prescribe any painkillers....any anti-inflammatories]

...haven’t recorded that I did

[MOD032881...first admission to the field hospital]

...I took him up to the A & E department

...[if the man was in pain...you would want the first dose....as soon as possible]

...that would be your aspiration

...and to have cleaned his wounds

...[obvious to you that this man was in some significant pain]

...[don’t think so]

...[would be surprising if he wasn’t]

...[with hindsight...of knowing what the X-ray showed...didn’t know that at the time]

...[prescribe him an antibiotic]

...[no...don’t routinely give antibiotics]

...[realistic risk of infection]

...[with hindsight]

...[you put ‘wound dorsal aspect of right foot, overlying swelling and tenderness, no obvious entry wound’]

...[recall the appearance not being overly alarming

...['superficial abrasions’ to the right thigh...and...’slightly deeper wound to the lateral aspect of the right knee’]

...[and superficial abrasions to the stomach and left elbow’...distinguishing between superficial wounds, slightly deeper wound and wounds]

...[debridement operation on the foot ...two stages...17 and ...20 May]

...[any evidence at all to suggest...pain relief ...before...hospital]

...[no]

...[regret any aspect of your treatment of him]

...[no, I’m jolly please I did send him to hospital...based it on my clinical findings
Re: Al-Sweady Public Inquiry - 11.4.2014 – JJ Payne-James

[why not send him up to hospital that night]

 wasn’t a clinical emergency…first time I had done it…had to speak to A & E to work out how we went about doing it

knowing now that there was a broken bone and retained foreign body…I am pleased I did send him

[775…Camp Abu Naji..’small laceration to the left side of the face in eye line. Wound glued’…..MOD034439…on 25 May…does that show a healing mark beside the left eye]

appears to

[would you agree that this must have been apparent as the time of your initial examination]

can’t say from this photo

suggests that it wasn’t apparent to me…may have been an oversight

[MOD048738]

light mark adjacent to the left eyebrow

.some bruises on the right eye

[don’t you think you would have seen that]

.possibly…either…oversight…or I forgot to write it

[wrists…appears to be marks of restraint to the detainee’s wrists…taken on 25 May]

could be marks of detention…not sure what the previous two are…could be old scars

[if…present on 15 May..think you should have seen them and recorded them]

.would hope I would have recorded marks I saw

.simple oversight or them not being visible or obvious at the time

.not sure that the handcuff marks would have been there…bruising can often appear some time afterwards

[779…Corporal Carroll…recorded no injury…you have recorded bruises and swelling of the right cheek]

.marked on the right cheek…also seem to have written left…not sure…I have put marks both sides

.cannot recall whether I used a black pen for bruising and a red pen for abrasions

[MOD048746…..bruises to the left cheek appear to be more evident]

.think that picture corresponds with what I have drawn down here

[did you ever ask detainees ‘how did you come about those injuries’]
Re Al-Sweady Public Inquiry - 11 4 2014 – JJ Payne-James

906 .no
907 .should have asked meore
908 [780…Corporal Carroll….’small piece of shrapnel remove from left side of face just in front of ear…grazed to left side of face around…eye area. Nil other injury’…Your body diagram…superficial abrasion to the left cheek and a small abrasion to the left large toe…doesn’t appear that you have spotted the injury…namely the shrapnel injury to the face in front of the left ear]
909 .I haven’t commented on it
910 .could have been a very tiny wound
911 [MOF048748…agree that that shows quit e an extensive abrasion across the left cheek]
912 .correlates quite well with the drawing I have made…this not being a forensic-type examination with measurements and photographs
913 [could you say that any of the injuries had been caused within the previous few minutes or hours as opposed to 24 hours earlier]
914 .I don’t think I would be able to say that
915 [you wouldn’t ordinarily run your fingers through the hair of a patient or a detainee]
916 .it wasn’t an inch by inch top to toe examination
917 [if you record an injury like a cut to an arm which has a bit of bloodstaining adjacent to it, or an injury to the nose which happens to have a little bit of blood at the base of the nose, would you normally record the blood distribution….or just record the fact of the injury]
918 .record the fact of the injury
919 [purpose of this medical examination was to identify any existing physical or mental health problem and to assess if the detainee was medically fit for detention. Is that right]
920 [do you recall receiving any indication from anywhere that the initial assessment you carried out of detainees had a purpose other than identifying whether that detainee might require medical treatment]
921 .don’t recall…
922 [do you recall ever being given to understand that the assessment you carried out had some sort of forensic function in the investigation allegations of abuse by detainees]
923 .no
[would it be fair to say...you approached this assessment when detainees arrived at DTDF as a doctor looking for symptoms, signs and history of clinical significance...in order to inform your decision as to whether or not treatment was required]

[772....notes from 16 May to 24 May indicate in a nutshell and eight-day course or thereabouts of intermittent vomiting with headache....nine sets of observations performed on this detainee during that eight day period...blood pressure, pulse, temperature and oxygen saturation....any abnormalities]

[how would you characterise the standard of care provided to a patient in a primary care setting with eight days of intermittent vomiting and headache nine separate consultations with a doctor or medic and nine sets of observations.....in an ordinary primary care setting, let's say the NHS a young, otherwise healthy young man with no apparent significant past medical history who has suffered from a week or so of intermittent vomiting and headache, would they expect to receive that level of medical intervention]

[final consultation...appeared to get better following what I think can be summarised as fairly conservative treatment: some Stemetil, analgesics, advice on diet and fluid intake...and some Hartmann’s solution....he appeared to be better]

[774...possibility he refused medication....would you force medication on a detainee in those circumstances]

[if you did miss a few, is that anything more than oversight on your part]

Medical Records, Assessments and Images of Detainees 772-780

I will make reference only to those matters which appear relevant to my instructions.

If accounts are given in the medical records for how detainees sustained injuries  I refer to them below.

Images are reproduced below – those with British soldiers are taken from Exhibit PMD/3a (it appears individually referred to in a series as MOD032673 onwards within oral evidence), the other are identified individually.

ASI025410
With the exception of the later images with scales these are of very poor quality being poorly reproduced (I have reproduced below from the digital files which I am informed are the best quality available), of poor detail, questionable focus, poor lighting and variable colour tones.

I have identified with arrows where there are obvious lesions (as opposed to possible photographic or reproduction artefact) that I am able to see within the limits of the images. I have not identified what appears to be dirt.

It is not possible to determine the natures of these lesions (eg red bruise vs simple skin reddening) from the images alone. Absence of arrows implies that from the images alone I cannot see an obvious abnormality.

In my opinion the general quality of the images is so poor that it would be wrong to use these for all but the most basic interpretation of where there may be abnormalities.

772 – Hamzah Almalje – MOD048732 – possible swelling of the nose – possible redness below the left eye:
DTDF Initial Medical records:

[090772..15 5 2004]

- weight 52kg, blood pressure 130/72, T 36.8

Medical Officer’s Comments

HS I+II+0

- abdo soft non-tender, no masses, bowel sounds present

- fit for detention..unkempt and dishevelled

[body diagram completed]

[subsequent records]

- 16 5 2004..refer to RMO

- 16 5 2004..advice from RMO

- 18 5 2004..stomach pain and vomiting…18 gauge cannula inserted

- 18 5 2004 [Dr Winfield] written retrospectively..abdo soft

- 21 5 2004 sore head stomach and back

- 22 5 2004 [Dr Winfield] headache/stomach pain..abdo soft.

773

963

964  773 – MOD048734

965

966  773 – MOD048735

ASI025413
DTDF Initial Medical records:
[15 5 2004 090773]
.pulse rate 117
.respiratory rate 17
.no medical problems
.Medical Officer’s Comments – Fit for detention.

774 – MOD048736
DTDF Initial Medical records:
[15 5 2004 090774]
. 2 gunshot wounds right thigh and right foot...Britfor troops carried out first aid
.no previous medical problems
.Medical Officer’s Comments
.Limping
.clean and dress wounds
.for X-ray right foot exclude fracture, retained foreign body.
. 775
Appendix 9: Report by Dr Payne-James

ASI: SECURITY CLASSIFICATION DOWNGRADED

Re: Al-Sweady Public Inquiry - 11.4.2014 – JJ Payne-James

990

991 775 – MOD048738

992

993

994 775 – MOD048739

ASI025416
The images below are taken with scales, properly lit and focused. Dates and times taken need to be confirmed.

The image below appears to show respectively - an irregular ~ 2.5cm linear mark which may represent a healing scar with glue:

The image below shows an ~ 2x1cm apparently healed area of loss of skin with additional linear scabbed abrasions to the right wrist area:
The image below appears to show linear partial circumferential scabbed lesions to the wrist – I cannot determine which wrist:

ASI: SECURITY CLASSIFICATION DOWNGRADED
Dr Winfield states:

have been asked by Sgt Phillips to check the medical records of internee 090775 who has made a complaint about being beaten and having his neck stamped on during his arrest.

my initial examination...he had superficial abrasions to his left scapula.

he did not have any further injuries.

I can state that during my examination I record all injuries that I can see and as I have not marked any other injuries then I can state that there were none.
Re: Al-Sweady Public Inquiry - 11.4.2014 – JJ Payne-James

Appendix 9: Report by Dr Payne-James

ASI: SECURITY CLASSIFICATION DOWNGRADED

1017
1018 777

1019
1020 777 – MOD048742

ASI025420

ASI: SECURITY CLASSIFICATION DOWNGRADED

1021
1022 777 - MOD048743

1023
1024 778 - MOD048744

ASI025421
ASI: SECURITY CLASSIFICATION DOWNGRADED

ASI: SECURITY CLASSIFICATION DOWNGRADED

Re: Al-Sweady Public Inquiry - 11 4 2014 - JJ Payne-James

1031
1032  779 – MOD048747

1033
1034  780

1035
1036  780 – MOD048748

ASI025423
The Table below summarises aspects of examination brought up in Dr Winfield’s oral evidence to the Inquiry, taken from information within the oral evidence:

<table>
<thead>
<tr>
<th>Detainee</th>
<th>Camp Abu Naji</th>
<th>Corporal Carroll</th>
<th>Dr Winfield</th>
<th>Interrogator</th>
</tr>
</thead>
<tbody>
<tr>
<td>772 Hamzah Almalje</td>
<td>Cut to his head</td>
<td>Large laceration to the left side of the head</td>
<td>Small abrasion above the left eye Swelling, bruising on the left cheek and the bridge of the nose and the right eye</td>
<td>Smelly and dirty...had dried blood covering his face...appeared to be in great pain and unable to stay upright...first session had to be taken out...looked concussed [16 May]. [21 May]...internee appeared to be in pain and...</td>
</tr>
</tbody>
</table>

ASI: SECURITY CLASSIFICATION DOWNGRADED
<table>
<thead>
<tr>
<th>Page</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>773</td>
<td>Mahdi Al Behadili</td>
<td>Slight bruising and swelling on the nose</td>
</tr>
<tr>
<td>774</td>
<td></td>
<td>Injury to the right foot, a gunshot wound, clean, no exit and dressed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Injury to the right leg, the lateral aspect of the knee: wound cleaned, dressed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grazed. GSW Gunshot wound to the upper right thigh. Cleaned and dressed.</td>
</tr>
<tr>
<td>775</td>
<td>Small laceration</td>
<td>Superficial abrasions to his left scapula.</td>
</tr>
<tr>
<td></td>
<td>to the left side of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the face in eye line.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wound glued.</td>
<td></td>
</tr>
<tr>
<td>776</td>
<td></td>
<td>Superficial abrasion to his left shoulder and left elbow. No other injuries.</td>
</tr>
<tr>
<td>777</td>
<td>Abrasion to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>his right knee</td>
<td></td>
</tr>
<tr>
<td>778</td>
<td></td>
<td>Superficial abrasions to both elbows and lower arms. Small grazes on his left scapula.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No other injuries</td>
</tr>
<tr>
<td>779</td>
<td>No injury</td>
<td>Bruises and swelling on the left cheek. Small abrasion on the face and small grazes on both elbows and right shoulder. Small graze on his left</td>
</tr>
</tbody>
</table>

ASI: SECURITY CLASSIFICATION DOWNGRADED

The Report of the Al-Sweady Inquiry
Guideline In Place and Good Medical Practice

A registered medical practitioner on the General Medical Council list of registered medical practitioners should abide by the General Medical Council’s publication ‘Good Medical Practice’. This is revised and updated every few years – the version in use at the relevant time was published in 2001 of which the most relevant parts to this report are quoted below which advises doctors on their duties. This guidance was withdrawn and replaced in 2006.

Passages that appear relevant to my instructions from ‘Good Medical Practice (2001)’ are reproduced below:

**Good Medical Practice**

All patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations.

**Good clinical care**

Providing a good standard of practice and care

Good clinical care must include:

- an adequate assessment of the patient’s conditions, based on the history and symptoms and, if necessary, an appropriate examination;
- providing or arranging investigations or treatment where necessary;
- taking suitable and prompt action when necessary;
- referring the patient to another practitioner, when indicated.
- In providing care you must:
- recognise and work within the limits of your professional competence;
- be willing to consult colleagues;
be competent when making diagnoses and when giving or arranging treatment;

keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed;

keep colleagues well informed when sharing the care of patients;

provide the necessary care to alleviate pain and distress whether or not curative treatment is possible;

prescribe drugs or treatment, including repeat prescriptions, only where you have adequate knowledge of the patient’s health and medical needs.

You must not give or recommend to patients any investigation or treatment which you know is not in their best interests, nor withhold appropriate treatments or referral;

report adverse drug reactions as required under the relevant reporting scheme, and co-operate with requests for information from organisations monitoring the public health;

make efficient use of the resources available to you.

If you have good reason to think that your ability to treat patients safely is seriously compromised by inadequate premises, equipment, or other resources, you should put the matter right, if that is possible. In all other cases you should draw the matter to the attention of your Trust, or other employing or contracting body. You should record your concerns and the steps you have taken to try to resolve them.

In making these disclosures you must follow our guidance Confidentiality: Protecting and Providing Information.

Decisions about access to medical care

The investigations or treatment you provide or arrange must be based on your clinical judgement of patients’ needs and the likely effectiveness of the treatment. You must not allow your views about patients’ lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age, or social or economic status, to prejudice the treatment you provide or arrange. You must not refuse or delay treatment because you believe that patients’ actions have contributed to their condition.

If you feel that your beliefs might affect the advice or treatment you provide, you must explain this to patients, and tell them of their right to see another doctor.

You must try to give priority to the investigation and treatment of patients on the basis of clinical need.

You must not refuse to treat a patient because you may be putting yourself at risk. If patients pose a risk to your health or safety you should take reasonable steps to protect yourself before investigating their condition or providing treatment.

Treatment in emergencies

In an emergency, wherever it may arise, you must offer anyone at risk the assistance you could reasonably be expected to provide.

Maintaining good medical practice

Keeping up to date

You must keep your knowledge and skills up to date throughout your working life. In particular, you should take part regularly in educational activities which maintain and further develop your competence and performance.
1063 Some parts of medical practice are governed by law or are regulated by other statutory bodies. You must observe and keep up to date with the laws and statutory codes of practice which affect your work.

1064 Maintaining your performance

1065 You must work with colleagues to monitor and maintain the quality of the care you provide and maintain a high awareness of patient safety. In particular, you must:

- take part in regular and systematic medical and clinical audit, recording data honestly. Where necessary you must respond to the results of audit to improve your practice, for example by undertaking further training;
- respond constructively to the outcome of reviews, assessments or appraisals of your performance;
- take part in confidential enquiries and adverse event recognition and reporting to help reduce risk to patients.

1066 …..

1067 Relationships with patients

1068 Obtaining consent

1069 You must respect the right of patients to be fully involved in decisions about their care. Wherever possible, you must be satisfied, before you provide treatment or investigate a patient's condition, that the patient has understood what is proposed and why, any significant risks or side effects associated with it, and has given consent. You must follow the guidance in our booklet Seeking Patients' Consent: The Ethical Considerations.

1070 Respecting confidentiality

1071 You must treat information about patients as confidential. If in exceptional circumstances there are good reasons why you should pass on information without a patient's consent, or against a patient's wishes, you must follow our guidance Confidentiality: Protecting and Providing Information and be prepared to justify your decision to the patient, if appropriate, and to the GMC and the courts, if called on to do so.

1072 Maintaining trust

1073 Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:

- be polite, considerate and truthful;
- respect patients' privacy and dignity;
- respect the right of patients to decline to take part in teaching or research and ensure that their refusal does not adversely affect your relationship with them;
- respect the right of patients to a second opinion;
- be readily accessible to patients and colleagues when you are on duty.
- You must not allow your personal relationships to undermine the trust which patients place in you. In particular, you must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them.

1074 Good Communication

1075 Good communication between patients and doctors is essential to effective care and relationships of trust. Good communication involves:

- listening to patients and respecting their views and beliefs;
• giving patients the information they ask for or need about their condition, its treatment and prognosis, in a way they can understand, including, for any drug you prescribe, information about any serious side effects and, where appropriate, dosages;

• sharing information with patients’ partners, close relatives or carers, if they ask you to do so, having first obtained the patient’s consent. When patients cannot give consent, you should share the information which those close to the patient need or want to know, except where you have reason to believe that the patient would object if able to do so.

1076 Working in teams

Healthcare is increasingly provided by multi-disciplinary teams. Working in a team does not change your personal accountability for your professional conduct and the care you provide. When working in a team, you must:

• respect the skills and contributions of your colleagues;

• maintain professional relationships with patients;

• communicate effectively with colleagues within and outside the team;

• make sure that your patients and colleagues understand your professional status and specialty, your role and responsibilities in the team and who is responsible for each aspect of patients’ care;

• participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies;

• be willing to deal openly and supportively with problems in the performance, conduct or health of team members.

1078 Leading teams

If you lead a team, you must ensure that:

• medical team members meet the standards of conduct and care set in this guidance;

• any problems that might prevent colleagues from other professions following guidance from their own regulatory bodies are brought to your attention and addressed;

• all team members understand their personal and collective responsibility for the safety of patients, and for openly and honestly recording and discussing problems;

• each patient’s care is properly co-ordinated and managed and that patients know who to contact if they have questions or concerns;

• arrangements are in place to provide cover at all times;

• regular reviews and audit of the standards and performance of the team are undertaken and any deficiencies are addressed;

• systems are in place for dealing supportively with problems in the performance, conduct or health of team members.

1080 …..
Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient.

Referral involves transferring some or all of the responsibility for the patient’s care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment, which falls outside your competence. Usually you will refer patients to another registered medical practitioner. If this is not the case, you must be satisfied that any health care professional to whom you refer a patient is accountable to a statutory regulatory body, and that a registered medical practitioner, usually a general practitioner, retains overall responsibility for the management of the patient.

Comments

Dr Winfield assessed 9 detainees on 15 5 2004.

One of the detainees - 774 - was subsequently found to have a foot fracture and foreign body. Dr Winfield had raised this as a possibility on the DTDF Initial Medical form.
The presence of a foreign body in the context seen may result in infection and thus diagnosis and treatment should be undertaken as a matter of urgency. Diagnosis would be confirmed by X-ray.

There appears to be no medical reason for delay in referral. One of the detainees - 772 - was reported to have intermittent headache, vomiting and stomach pain, some of these symptoms apparently pre-dating detention. Dr Winfield examined the abdomen on Initial Medical.

He then examined the abdomen apparently on the 18th and 22nd May. Observations (but not abdominal examination) were undertaken by RMAs 1 and 2. 772 was administered intravenous Hartmann’s solution. No diagnosis was made.

I would expect persistent symptoms of headache and vomiting and stomach pain to be referred to an Emergency Department for further tests and possible observation, to identify or exclude infection or dehydration, prior to the administration of intravenous fluids.

Injuries should be documented and described in written notes, supplemented by body diagrams if possible. The minimum information recorded should be, position, nature, and size of each injury. Photographic imagery can be used but needs to be appropriately undertaken. Dr Winfield states ‘I can state that during my examination I record all injuries that I can see and as I have not marked any other injuries then I can state that there were none’.

The medical records and photographic and other evidence suggests that Dr Winfield did not achieve what he stated above in relation to all the detainees.

ASI025430
The use of photographs in the absence of colour scales and rules to determine size, nature, colour or relative colour of injuries or possible injuries, is in my view, inappropriate as this renders images open to wrong interpretation, or to no interpretation at all as a recent collaborative study with the Metropolitan Police Service, the National Crime Agency and Barts and the London School of Medicine and Dentistry has shown (Payne-James JJ, Hawkins C, Bayliss S, Marsh N. Quality of photographic images for injury interpretation: room for improvement? Forensic Sci Med Pathol 2012 DOI 10.1007/s12024-012-9325-2).

Conclusions

With respect to my instructions I make the following conclusions subject to the provision of additional evidence and subject to review of the information that I have requested in bold in the preceding report:

provide opinion on the appropriate professional standard that applied to the examinations conducted by Dr Winfield - Dr Winfield undertook medical assessments of a number of detainees. The evidence confirms that his examinations in some cases were inadequate, in that certain injuries were not recorded. It is important to seek accounts in the history for the cause of each injury as this may be relevant with regard to management and identification of complications.

Additionally, to consider a number of issues raised during the course of Dr Winfield’s evidence:

(1) Dr Winfield’s evidence in relation to not asking a patient about the occasion/cause of any injury, when taking a history [144134-37; and 1441160-1] – it is appropriate to ask about the cause of any particular injury as part of routine history taking. The possible cause of the injury may influence what the possible diagnoses or range of complications or underlying issues may need to be considered.

(2) Dr Winfield’s evidence in relation to not asking to see any previous medical documentation for the detainees: [144148-49] - generally if it is known that other medical documentation exists then it is appropriate to review it. Whether or not it is available does not detract from the need to undertake a full history and examination.
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1108 (3) Dr Winfield’s evidence that the head merits no more attention than any other part of the body (including when there are facial injuries apparent) [144183] – if the head has been subject to impact trauma there are specific conditions that may need to be excluded or monitored. Impacts (which may be indicated by bruising, lacerations, grazes/abrasions) may result in brain damage, the effects of which may not be immediately obvious. Documentation of the history (including any loss of consciousness) nature of the impact and the nature of the injury may modify subsequent management in terms of observation required

1109 (4) Dr Winfield’s evidence that he was justified in not noting the presence of blood under the nose of a patient, and in not wiping it away (at page 92 he states, in response to a question that [we] were not responsible for their [i.e the detainees] hygiene) [144189-92] – blood in association with a nose injury could reflect a fractured nose. Cleaning of an area of blood may be required to determine the source of the blood. Examination of the nose (by palpation) and by examining in the nostrils will assist in determining whether a nasal fracture is present and requires reduction, or any complication such as septal haematoma which may require treatment

1110 (5) Dr Winfield’s evidence that Hamza Almalje (Detainee 090772) would have been lucky to receive the care that he did [between 15.5.04. and 24.5.04] on the NHS [1441165-6]: I believe that an undiagnosed 8 day episode of intermittent headache and vomiting would generally precipitate referral to hospital for assessment and possible admission, and additional tests in order to make a diagnosis, even in the presence of normal blood pressure, pulse, temperature and oxygen saturation. I would be very surprised if anyone administered intravenous fluids to such a patient in a primary care setting

1111 (6) Dr Winfield’s evidence that it was right to place substantial reliance upon objective recordings, and to have regard to ‘transcultural medicine’, when assessing the apparent symptoms of Hamza Almalje (Detainee 090772) during this period [1441106-7] – Dr Winfield is correct to place substantial reliance on objective recordings (by which I am assuming he means clinical examination) but this would be in the context of an appropriate history. I am unclear as to what influence he is suggesting that ‘having regard to ‘transcultural medicine’ would have on his diagnosis and management plan.
Dr Winfield’s evidence that there was no point in examining for a broken nose or recording blood under the nose [1441116-119; and 154-155] – see answer to Q(4). Palpation of the nose can determine if fracture is present. If there is displacement of nasal bone (which need not cause midline deviation) then this may require surgical reduction. Additionally complications such as a septal haematoma may be missed. X-ray may be delayed for a week until swelling has reduced. Recording blood and its apparent source may be relevant with regard to the causation and location of injury.

Dr Winfield’s evidence that he was justified in not referring Ibrahim Al Ismaeli (Detainee 090774) to hospital for immediate x-ray to his wounded foot and waiting for another 16-18 hours before doing so [1441132-134] – in the light of the limping, swelling and tenderness, which in the context of the patient could be consistent with a fracture, there would be no medical reason for delay. The management options (eg non-weight bearing) could not appropriately be determined until a diagnosis was made (even in the absence of considering a foreign body – which he had, in case done).

Statement of Truth

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

Concluding Certificate

I certify that

a) within this report I have set out the substance of all material instructions whether written or oral, on the basis of which the report was written.

b) I have endeavoured in this report to include within this report those matters, which I have knowledge of or which I have been made aware that might adversely affect the validity of my opinion.

c) I will notify those instructing me immediately and confirm in writing if for any reason this report requires any correction or qualification.

d) I understand that:

i) It is my duty to help the court on the matters relevant to my experience and

ii) This duty overrides any obligation I may have to any person from whom I have received instructions or by whom I have been or will be paid

iii) I have complied with my above duty to the Court
I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

Signed __________________ Jason Payne-James 11th April 2014