First Supplementary Report of Mr. Jon Collier

Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017

FIRST SUPPLEMENTARY REPORT OF MR. JONATHAN COLLIER, HMPPS
3rd MARCH 2022

Brook House Inquiry

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Introduction

This is my first supplementary report and should be read in conjunction with my first report[1] provided to the Brook House Inquiry dated 14th January 2022.

This report has been produced to consider and comment on the additional material that the Inquiry has received since the completion of my first report.

Evidence from the first phase of hearings in November-December 2021 have also been included within my report.

There are responses to questions from Core Participants that were generated from my first report, these are listed as Annexes 1-4.

I have set out my responses to the material within my report as follows:

1. Questions relating to specific matters that are not new evidence.
2. Questions of clarification from my initial report.
3. Questions relating to new documents not previously considered.
4. Responses to questions received from Core Participants.

[1] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022.

A. Questions relating to specific matters not relating to new evidence

1. Prone Restraint

1. 1 I addressed the use of prone restraint in my first report[2]. I have been asked to comment further on this point and in particular to consider the analysis of prone restraint in the 2014 Report of the Independent Advisory Panel on Non-Compliance Management 3 (IAPNCM) and the findings of that report which state that restraint on the ground must be avoided if at all possible and in particular prone restraint must be avoided given the high risk of death.[3]

1.2 The UOF training contains guidance for staff regarding the risks of prone restraint. It re-iterates the message that prone restraint should be avoided and that all efforts should be made to keep the detainee standing. If a restraint does go to the ground it should be for the shortest time necessary, with continued monitoring of the detainee and for all restraints to be removed or modified if a medical emergency became known to the staff or is the detainee states he was experiencing problems.

1.3 Similarly, if a member of healthcare was in attendance they could instruct staff to remove or modify the restraint. Paragraphs 4.31-4.32 of the above report[4] confirm that the techniques demonstrated from[5] the HOMES manual were accepted, provided all guidance and advice was in place. These techniques are the same as in the UOF training manual used at Brook House during 2017. I note the recommendations in paragraph 1.18, bullet points 5 and 6, for scenario-based training and management/monitoring of force. These relate to my recommendations 6 and 3 respectively.[6] Paragraph 1.20 acknowledges that the risk of positional asphyxia should be avoided whenever possible and that any such use in exceptional circumstances must be the subject of guidelines designed to reduce to a minimum the risks to the health of the person concerned.

1.4 It should be noted that the above panel were specifically considering the UOF on detainees during either the in-country (bespoke vans) or overseas escorts (aircraft). The UOF syllabus they evaluated was the HOMES course, delivered only to approved escort providers. The scenarios for using force were different to those within a secure setting, most notably the space and confines, for instance carrying out a restraint in an aircraft presents different risks to when using force in a room at Brook House. The one common theme is the risk of prone restraint and the staff awareness and medical provision available.

1.5 I have been asked to clarify whether clinical guidance and practices on the use of prone restraint is relevant to any assessment of the appropriateness of the use of prone restraint on

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[2] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022, Page 24, paragraph 69 and page 27 paragraph 96.

[3] 2014 Report of the Independent Advisory Panel on Non-Compliance Management 3

[4] 2014 Report of the Independent Advisory Panel on Non-Compliance Management 3, page 32.

[5] 2014 Report of the Independent Advisory Panel on Non-Compliance Management 3

[6] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022, Recommendation 3 page 148 and Recommendation 6 page 151.

clinically vulnerable individuals within the IRC context. In my view, clinical guidance and the establishment of informed practices form part of all restraints, with a special attention to those techniques which provide the greatest risk, for instance prone restraint. Continued work in this area is vital and the Introduction of the medical DVD to support the training manual evidences the progress made. Before any planned incident information from healthcare is cascaded to staff during the briefing. The attendance of healthcare staff with essential medical equipment should result in immediate attention being available should a detainee experience any problems or medical risk signs.

1.6 Further, I am asked to clarify and outline the extent to which I have considered mental health and other vulnerabilities in reaching my findings on prone restraint. I confirm I have no detailed information on the mental health of the detainees involved in the incidents that I reviewed. I do accept that many had committed acts of self-harm. Therefore I did not factor this into my findings.

1.7 I am instructed to review all the case examples provided by the Inquiry to ensure that all instances of prone restraint have been accurately identified and considered within this report. I identified only one case, incident 169/17 involving D812[7]. I have no information on the previous incident. I am satisfied that my findings on other restraints where the prone position was used reflects my understanding and knowledge of the risks associated with prone restraint. I have given evidence at many Coroners Inquests where prone restraint was a factor and confirm training highlights these risks and how staff are to respond. The inclusion of the restraint recovery position into the manual is evidence of advice being included into training. The inclusion of the restraint recovery positions follows advice from Dr Maconochie during his review of the physical restraints being proposed for the revised training manual.

2. Pain-compliance techniques

2.1. At paragraph 273 of my first report I make reference to the use of pain compliance techniques within the IRC context.[8] I am asked to consider clinical guidance and practices on the use of pain-inducing techniques (PIT) and to provide my opinion on their relevance to any assessment of the appropriateness of the use of these measures on clinically vulnerable individuals within the IRC context.

2.2. The use of PIT is covered within the training manual and evaluated within the 2014 Report of the Independent Advisory Panel on Non-Compliance Management.[9] Their conclusion is that 'We have concluded that there are circumstances in which pain inducing techniques are both necessary and justifiable. In the Panel's judgement, they are justifiable only when: The use of such techniques is the safest and most appropriate way of dealing with an incident, or of gaining control of a violent subject. In such circumstances, the use of pain inducing techniques to achieve compliance would carry less risk than other means' and 'the Panel has concluded that pain inducing techniques are justifiable, in the interests of reducing the risk of injury to

[7] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022, Page 124.
[8] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022, Page 70.
[9] 2014 Report of the Independent Advisory Panel on Non-Compliance Management 3, page 33-34 paragraphs 4.7-4.8.

detainees and to staff'. I also note the comment 'To date, the Panel has not been presented with an academically sound, peer reviewed study to persuade us that pain-compliant techniques can be wholly dispensed with'.[10]

2.3. Before a planned removal, information should be provided to staff if the detainee is clinically vulnerable or has any significant pre-existing injuries. All restraints must only use the force necessary and for the shortest time but on occasions where the guidance permits the use of a PIT could assist in bringing a swift resolution to an incident that would otherwise become protracted and possibly cause injuries to the detainee or staff, and in addition a prolonged restraint may have a negative psychological impact on the detainee.

B. Questions of clarification

I have been asked to clarify a number of matters in my first report. I set these out at B1.2 – B4.2 of this report.

1. Use of Force Incident log queries

1.2 UOF Incident log 157/17 – D149[11]

In the case of D149, I make reference to the use of handcuffs and the justification for their use in the circumstances. I did not (in paragraph 532 of my report) state I was 'confused' for the use of handcuffs. It was unclear and confusing why the UOF form reported force being used for failure to comply with removal and non-compliance. Paragraph 535 relates to my opinion that the use of handcuffs to move a person would be reasonable and necessary when moving a detainee who on previous incidents demonstrated challenging behaviour, and to be placed in handcuffs for a removal due to the security and safety risk.[12] This would be an individual management plan for those who present a risk or where local security measures are compromised. In this case previous intelligence of an escape risk and trying to take staff keys (ref incident 135/17)[13].

1.3 UOF Incident log 162/17 – D2054[14]

In the case of D2054, at paragraph 315 of my report I state that there was "no evidence of any excessive force" and that staff applied all techniques correctly[15]. I am referred to my finding at paragraph 318 where I stated that, following the initial application of force to engage the removal, the "continued force demonstrated was not necessary or proportionate" and

[10] 2014 Report of the Independent Advisory Panel on Non-Compliance Management 3, page 34, paragraph 4.9.
[11] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 125.
[12] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 126.
[13] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 21.
[14] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 74.
[15] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 79.

"should have been deescalated".[16] It is stated that these findings are difficult to reconcile and I am asked to clarify my opinion insofar if force ceases to be necessary, is it not inherently excessive by virtue of its continuation?

1.4 This is subject to interpretation of the general principles for using force. If for instance staff applied a Pain Inducing Technique (PIT) for longer than necessary or when there was no justification for its use that would be deemed excessive, as would be using a personal safety technique toward someone making a passive protest. Failure to remove restraints when no longer necessary could also classed as excessive but are normally classed as not being necessary or reasonable. I accept that, while the use of force in this instance was initially necessary and proportionate, the continued use of force beyond the point when D2054 no longer presented a risk, and when control had been gained, could be classed as excessive.

1.5 UOF Incident log 109/17 – D191[17]

I am referred to my findings at paragraphs 187 and 190 where I state that it was not necessary or proportionate to maintain the wrist flexion throughout the removal, when the lesser restrictive measure of handcuffs would have been more suitable especially given the behaviour was suspected to be linked to his being under the influence[18]. It is stated that this view does not however align with my support for the findings of the PSU investigator, which included that the claim of excessive force was unsubstantiated (paragraphs 176-177)[19].

1.6. As with my comments above the definition and interpretation can be subjective. Yes it was necessary to use force but it was more the decision making as to what level of force that raised concerns. There was no evidence to suggest excessive force was used with the holds that were applied. In my experience the application of handcuffs allow the option for restraints to be removed and can assist with de-escalating the situation. When managing those under the influence of alcohol or drugs, or those who are at a heightened state of aggression, their tolerance to pain increases and they can summon high levels of strength. Handcuffs provide additional control and restraints can be removed or re-applied depending on the circumstances of the incident.

2. Terminology

2.1 In the case of D390, I am referred to my finding that the force was "lawful" under DCR R43 (10), however, that it was not necessary or proportionate (paragraphs 259-264)[20]. Given that my instructions are to consider whether the UoF incidents were in accordance with general UoF principles, as set out in the C&R training manual, and whether appropriate techniques

[16] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 79.
[17] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 45.
[18] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 48.
[19] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 47.
[20] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 65

were used (see paras. 5(d) and 7 I am asked to clarify the use of language "lawful" in this regard.

2.2. I am also referred to other paragraphs, 559, 589 and 619 of my report where I comment on the "lawfulness" of the UOF incident.[21] I am asked to clarify whether I am referring to the statutory provisions which were relied upon in a specific instance and capable of authorising the use of force.

2.3 My response to the questions is that my assessment is in the context of the UOF incident falling under the Detention Centre Rules, and the term lawful relates to the DCRs rather than as an assessment of legality. I am aware of my role and that I do not make judgements on questions of law. I can confirm that the heading- 'Lawful under Detention Centre Rules' is taken from either the UOF report submitted by the Supervising Officer, or when not noted, my understanding of the respective rules applicable to this incident. I do not profess to know the finite details of each rule, or the circumstance with each respective incident, and use them only to state the centre rules that authorise force. Ultimately even if force is lawful it must still only be used within the general principles.

3. Training

3.1. I am asked to clarify my position in relation to the following queries on training:

3.2. 'You refer in your previous report to Sussex Police in relation to the use of force by Yan Paschali on D1257[22] (paragraph 44). You endorse that report in full at paragraph 663.[23] In that report you refer to UoF training being 'cascaded' to IRC staff through accredited C&R instructors. You state that all custodial staff are required to complete a UoF course within their initial officer training course ('ITC') which covers the 'entire manual' and thereafter refresher training which covers four mandatory elements (paragraph 4). You then say "the remainder of the course will be decided by the instructors and focus on the elements that are assessed as most appropriate for their establishments, or to replicate recent incidents" (paragraph 4). I am asked to respond to the following questions:

3.3. (i) Confirm whether reference to the 'remainder of the course' relates to the initial training course or only the refresher training;

3.4. I confirm this refers to the refresher course only. The initial course covers the entire manual (with the exception of sections not relevant- for instance in an IRC the sections on batons and bodybelt)

3.5. (ii) Specify any guidance available to local instructors when making decisions as to which training elements are most appropriate for their establishments;

3.6. When deciding what the remainder of the course should cover it will be directed by the local UOF committee and/or local Instructors. Factors to consider for what is included will be, the

[21] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 pages 131; 136; 141.
[22] [SXP000133] - Report by Jon Collier to Sussex Police (DC Stephen Trott) - 06.02.2018 - Detainee D1527 Annex Documents - Annex A - SXP000130 - Annex B - SXP000134.
[23] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 158.

training needs of the particular group on the day, previous incidents where good practice was observed, recent incidents where there was room for improvement, current themes or trends within the centre- for instance if recent removals involved detainees being undressed, or a spike in incidents within a particular area, such as the visits room. Recommendation 6 addresses the criteria for scenario based training.

3.7. (iii) Confirm the nature and extent of any mechanisms for oversight and quality assurance of locally delivered training (whether by HMMPS national trainers or senior management within the relevant establishment).“

3.8. In my opinion, the first level of oversight and assurance comes from the instructors being required to attend an annual revalidation at the national training centre for their Instructor accreditation. This ensures they remain in possession of the necessary skills and expertise to deliver training at their establishment and for any update son training/policy/practice. All training delivered locally must be delivered by a minimum of two Instructors. This allows a degree of peer observation, which is encouraged but at present is not formally mandated. There is no senior management requirement other than viewing or participating in training and giving feedback. This is open to local directives, but it is encouraged that those who may investigate UOF incidents to have up to date training in the syllabus.

3.9. “In your report to the Inquiry, you state that the UoF training manual contains a mandatory element on ‘medical advice’ which is supported by a ‘DVD’ (para. 639). Similarly in your report to Sussex Police you list various topics covered in this ‘Medical DVD’ shown to staff prior to their UoF training (para. 9), none of which appear to address vulnerabilities relating to mental illness, a history of torture, ill-treatment or other trauma. You are asked to confirm:

4. (i) Whether the above list is exhaustive of the areas covered within the medical dimension to the UoF training provided at the material time.

4.1. I confirm the advice comes from viewing the medical DVD and the sections covering medical considerations within the training manual only. There is no further advice given.

4.2 (ii) Whether there is any input into this training from medical professionals on the considerations that apply when using force against individuals with mental illness and/or history of torture?

4.3. I confirm I do not know the extent of the review by Dr Maconochie or what areas he considered when producing the report and advising on the medical section of the training manual.

(iii) Whether such input should be included in the ‘bespoke communication package’ for IRC staff.

4.4. On reflection of the evidence from this Inquiry and the growing number of prisoners suffering similar experiences/trauma it is my opinion this should be included within any curriculum that manages vulnerable people. Specific advice when applying force would be essential for ensuring the wellbeing of those involved and assist staff with their decision making process and help to inform local healthcare staff of the potential risks if, after all other efforts are unsuccessful, force is used as a last resort.

4. Article 3 breaches

4.1. "At paragraph 663 of your report you state that the incident "could be contrary to Article 3..." Please can you clarify that you understand that this is not a matter for you to determine, but for the Chair?"

4.2. I agree that the Chair will determine any breach of Article 3. I do state that it could be contrary to Article 3. My reason was to cross reference the UOF Training Manual which covers Article 3 in some detail. Staff receive this training and are expected to behave in a manner that exemplifies respect and dignity toward those who we care for in line with ECHR. This is based on my knowledge of the UOF curriculum and my operational experience in managing incidents.

C. Questions relating to new documents not previously considered

I have been instructed to review the following material and comment upon the relevant provisions. I have broken these down into subtopics which are relevant to the Inquiry's terms of reference.

C1. Staff/Former Staff Witness Evidence to Brook House Inquiry

1. Callum Tulley

First Witness Statement[24]

I have reviewed this witness statement and make the following comments.

UOF – Staff attitudes

1.1 I refer to paragraph 44-61 of this statement which details a UoF incident in 2014 when a detained person was naked and was mocked by officers. I can confirm that when a full search (no longer referred to as strip search) is necessary the detainee is provided with replacement clothing and or a gown. The process involves removing the clothing when face down and if staff have to relocate the room a blanket is placed over the buttocks to preserve an element of dignity. The comments that staff were mocking and laughing would be unacceptable behaviour and should be addressed at the time by the incident supervisor.

1.2 From other evidence I observed there are occasions when staff use inappropriate comments and language. The bravado that surrounds using force appears to go unchallenged and it is not a good example (paragraph 69) when managers use language that is degrading and offensive toward detainees.

UOF - Training

1.3 I refer to paragraphs 63 & 65 of this statement which details a UoF incident involving an American Jewish detained person, described as being completely unnecessary. This actually describes a planned intervention, DCM Panel Instructed three officers to restrain the detainee. This further confirms my comments that staff are unaware of the difference between planned and unplanned. The circumstances appear to indicate that this was a passive protest and that no immediate risk was presented to staff or others. The one factor was the time- 20:55 which was lock-up. Despite this the expectation is that staff continue with persuasion and try to find a peaceful resolution. It must be considered that force was used so quickly in order to relieve staff of their duties and allow night state to proceed. Mr Tulley is correct that this should not in effect result in using force to avoid inconvenience and that the same lawful justification remains, regardless of the impact on staff or regime of the centre.

1.4 I refer to Paragraph 184 where the witness states DCO Murphy was bragging about C&R. The description of how to correctly use a shield is covered within my report and I can confirm that

[24] [INQ000052] Witness Statement of Callum Tulley dated 15 November 2021.

the description given by DCO Murphy is not consistent with training. In any case it is not appropriate to deliberately push a detainee's face into his faeces and urine.

1.5 I have been provided with and reviewed the following documents and have no comments to make in respect of the same:

(i) Second witness statement of Callum Tulley[25]

(ii) CT2 – Answers to specific questions and CT3 – Table re Key Footage[26]

(iii) First witness statement given by Callum Tulley to the police[27]

(iv) Second witness statement given by Callum Tulley to the police[28]

Callum Tulley

Transcript: 29 November 2021[29]

UOF – Adequacy of training[30]

1.6 I set out in my first report the training for staff at the time.[31]

1.7 The allotted time for the full UOF course to be delivered is 32 hours. It must be taken into consideration that there are elements within the syllabus that are not applicable to Immigration Removal Centres, for instance use of batons and body belts. The course includes personal safety training, which is also taught to non-operational grades, for instance faith leaders, medical staff and teachers, and the section commonly referred to as Control and Restraint (C&R), which will include planned and unplanned UOF and the role of the supervising officer. The course starts with theory-based elements covering The Law, Communication, Medical Considerations and Report Writing. After the syllabus have been completed staff undertake a competency-based assessment before being accredited.

1.8 Refresher training is every 12 months and will incorporate the four theory-based elements as mandatory topics, with the remainder at the discretion of the local Instructors. With the Introduction of SPEAR (personal safety) training, use of PAVA (although not in IRCs) and Rigid Bar Handcuffs (RBH) the course will be extended. Final details have not yet been published.

1.9 It has only recently been agreed, within HMPPS, that refresher training will increase to 2 days annually. One day for C&R and one day for personal safety. The actual content has yet to be decided.

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[25] [BBC000651] Second Witness Statement of Callum Tulley dated 15.11.21.
[26] [BBC000653] CT2 - Answers to Specific questions and CT3 -Table re Key Footage dated 15.11.21.
[27] [CPS000018] Witness statement of Callum Tulley dated 23.11.2017.
[28] [SXP000118] Witness statement of Callum Tulley dated 24.03.2018.
[29] [INQ000106] Callum Tulley Transcript: 29 November 2021
[30] [INQ000106] Callum Tulley Transcript: 29 November 2021 Pages 32-36; 39-40.
[31] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 147 paragraph 641.

2.0 With the forthcoming increase in training it has to be accepted that more training was necessary, although this is due in the main to a new syllabus that includes SPEAR & RBH. The most important part of training is the scenario-based training. This is designed to pressure test all skills taught to staff and encompass not only UOF training but also de-escalation and decision making. The communication section within the UOF manual serves to re-iterate other core training and not to be the sole form of building relationships and managing challenging/difficult/complex behaviour.

UOF - Record keeping – Accuracy and Reliability

2.1 I am referred to pages 49-51 of the transcript where Mr Tulley describes how he was taught to use specific language when filling out use of force forms which "did not accurately describe how the use of the shield was sometimes used" (see page 50). I am asked to consider to what extent, if any, such an approach may impact on the accuracy and reliability of the use force records. I am not aware of any specific terminology to be used, including the term-'place the shield'. The report should be the individuals own account of the incident and must be completed independently, no collusion. Training gives advice on how to structure the report and the key information required, and with the exception of the opening statement the remainder is the individual person's wording, terminology and language.

2.2 With regards the term 'support the head' I can state that is exactly what is taught and what should be written. The term head support officer is used as this role involves the officer supporting the head of a person whilst they are restrained. The reasoning is to prevent the head moving around and potentially injuring themselves or others and to assist with stabilising the body and bring a swift resolution to the incident.

Callum Tulley

Transcript: 30 November 2021[32]

I have reviewed this transcript and make the following observations

UoF – Planned intervention

2.3 I have been asked to consider the Chairs question re planned use of force.[33] Debriefs are covered within PSI 30-2015 and should be conducted with staff after every UOF incident. I did observe several incident debriefs within my evidence packs, although most of these were only for planned UOF incidents.

2.4 "Immediately following any and all use of force, a "hot debrief" must be completed to identify if there are any injuries or immediate security concerns including the risk of further violent behaviour. The hot debrief should be led by the supervisor or Orderly Officer (or other person in overall charge of the incident). Staff attending the debrief must note attendance in their staff statements (see para 2.36 above). The person leading the debrief must follow up any concerns he/she has about the incident, techniques and methods used by any staff involved".

[32] [INQ000108] Callum Tulley Transcript: 30 November 2021.
[33] [INQ000108] Callum Tulley Transcript: 30 November 2021 Page 92.

2.5 Once the Use of Force Form and all Annex As have been completed by all staff involved, it is good practice for them to receive a follow-up general debrief. Wherever possible, the Use of Force Co-ordinator or Use of Force trainers should be involved. The follow-up debrief should be led by the supervisor (planned use of force) or Orderly Officer or wing manager (spontaneous use of force) or Safer Custody lead. This debrief should cover (as a minimum):

- why force was used;
- what attempts were made at de-escalation;
- what alternative approaches might have been employed (if any).

2.6 The person leading the follow-up debrief should discuss any concerns about the incident, techniques or methods used by any staff involved. Staff must note the date and time of the debrief at the bottom of the staff statements". [34]

Callum Tulley

Transcript: - 01 December 2021[35]

I have reviewed Mr Tulley's transcript and make the following observations.

UoF – Planned and Unplanned interventions[36]

2.7 Unplanned incidents are spontaneous actions that present a potential imminent risk of harm, either to self or others. Acts of disorder, security breach or escape would also fall under this category. In these instances staff have no time to prepare and must act instantly. Force must remain the last resort and follow the general principles, but it is accepted that the techniques taught for a three-officer team are not always possible. Staff may adapt techniques and use reasonable force until such time as sufficient staff arrive. Supervision of the incident will revert to the planned role once a suitable person arrives on scene.

2.8 Planned incidents occur when there is time to prepare staff and when there is not an imminent risk of harm/disorder but when a resolution strategy includes intervention. All efforts must involve negotiation and persuasion to achieve a peaceful resolution. A designated supervisor will manage the incident and in addition to the intervention team support staff, such as healthcare, evidence gatherer must attend. Planned incidents can include spontaneous acts when there is not an imminent risk, for instance refusing to move from a particular area, which effectively becomes a passive protest. Although it is advised for staff to be issued PPE a judgement must be made as to the level of risk for each individual case. The incident supervisor would record their justification for authorising force on the UOF form.[37]

UoF – Identification of DCOs by Detained Persons in UoF incidents

2.9 I refer to page 23 and 42 of the transcript. Balaclava's are not approved PPE for local planned interventions and definitely should not be used to withhold the identity of staff involved from

[34] PSI 30-2015.
[35] [INQ000097] Callum Tulley Transcript: 1 December 2021.
[36] [INQ000097] Callum Tulley Transcript: 1 December 2021 pages 17-23.
[37] [INQ000097] Callum Tulley Transcript: 1 December 2021 page 20.

the detainee.[38] Any staff involved in a planned intervention must be able to be identified.[39] This is normally through helmet numbers. Other methods could include ID numbers on the overalls. During the recorded initial briefing staff must identify themselves to the camera and give their identification number. The identification of staff is essential for the review process and for training purposes when good/poor practice is observed. In order to investigate individual actions identification is essential and the investigating officer must be able to identify each member of staff.

UoF – Report writing

3.0 I refer to pages 28-29 of this transcript. Training for report writing is within both initial and refresher training for staff. Staff are aware of their responsibility and know that a UOF report must be completed whenever force has been used, this includes for personal safety, unplanned and planned incidents. They should also be completed if the force was simply applying handcuffs to move to another location. PSI 30-2015 states that the form must be completed within 72 hours. I am now aware that the contractual agreement for Brook House states completion within 24 hours.

UOF Incident log (not recorded - possibly 105/17) - D1527

3.1 I refer to the above incident log. I have no evidence of a formal hot debrief taking place. There is some dialogue between staff, namely Mr Tulley and Mr Paschali around the completing of UOF reports at paragraph 35. To my knowledge staff do either wear name badges or have embroidered polo shirts. During unplanned UOF incidents the identification of staff is normally by individual recognition. See comments above for planned incidents.

3.2 Regarding the incident on the 27th April 2017 I provided my opinion in paragraphs 32-53 of my report[40] Having read the transcript of Mr Tulley it now appears that D1527 was being restrained by three staff before Mr Paschali enters and takes control of the head. The description of how he applied force corresponds with the undercover footage. In this circumstance all staff involved must complete a UOF report.

3.3 From the description explained by Mr Tulley for the initial restraint I am unsure on how D1527 was strangling himself. I do accept that if he was in the act of self-harming staff should intervene to prevent further harm. On page 106 paragraph 16 Mr Tulley explains that not much force was used. Then Mr Paschali comes in and takes control of the head. If little force was needed the expectation is to remove staff from the restraint, not add.

[38] [INQ000097] Callum Tulley Transcript: 1 December 2021 page 23 and 42.

[39] [INQ000097] Callum Tulley Transcript 01 December 2021 pages 23-28; 41-42.

[40] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 15-20.

Callum Tulley

Transcript: - 02 December 2021[41]

I have reviewed this transcript and make the following observations.

UOF incident Log 114/17 – D1527[42]

3.4 I refer to this incident in my first report. Paragraphs 282, 655, 656 of my report and recommendations 1 & 10 cover the management of incidents of this nature. I note the conversation between Mr Tulley and DCO Fraser, and a conversation with DCM Dix (page 4 paragraph 16-23 of the transcript which demonstrate poor levels of concern and unprofessional attitudes by the two staff.

3.5 At page 7, paragraphs 22-25 and page 8 paragraphs 1-4 make reference to the confusion and lack of control over the incident scene. Based on the account of Mr Tulley the staff are unsure of what to do in this situation and no clear strategy or leadership is evident.

UOF incident log 120/17 – D687[43]

3.6 This incident is referred to at pages 8-39 of the transcript. My opinion of this incident remains as within my report at paragraphs 220, 22 and 227. At paragraph 220 I list the time from entering dialogue with D687 as 11 minutes until the force is initiated (not taking into account the period before filming commenced). It was clear to staff that D687 was in distress and continued engagement should have taken place. At paragraph 222 I note the confusion on how the ligature was removed and this is confirmed in the transcript from Mr Tulley.

3.7 I also remain of the opinion, based on my professional experience and knowledge of UOF training and policy, that this incident should have been managed as a planned intervention, paragraph 227. This would have resulted in additional evidence being available from a handheld device, and as identified within my report the lack of BWVC evidence when two DCMs were on scene is unacceptable.

3.8 Paragraph 664 and recommendation 3 of my report address my concerns over the governance and scrutiny of UOF incidents. The review process in place at the time did not meet the necessary standards, as outlined in PSI 30-2015, and the major issue with a delay, for instance two and a half months in this case, is that any lessons learnt or evidence of wrongdoing go undetected for an unacceptable period of time and risk repeat behaviour/actions taking place.

[No UOF incident log] – D275[44] - Staff culture/Language

3.9 I have reviewed pages 39-57 of this transcript. My first comment is that language of this sort is not acceptable within society. It does not comply with the professional standards for Home

[41] [INQ000098] Callum Tulley Transcript 2 December 2021.
[42] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 68-72, paragraphs 268-294.
[43] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 55.
[44] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 66.

Office staff and gives a negative impression on the organisation, as per paragraph 267 of my report. Staff should actively challenge incidents like this and if they feel uncomfortable doing so they must use the reporting wrongdoing hotline, or approach a senior manager. This needs to become the accepted principles within the centre and for all staff and detainees to have confidence in the system for dealing with acts of an inappropriate nature.

4.0 As a UOF Instructor you are held in high regard by staff, especially relatively new and inexperienced staff. Some of the staff I observed at Brook House, Mr Tulley for instance, were of an age where they can be easily influenced by the more senior colleagues. Some of the conversations regarding Mr Paschali almost hold him in high regard. It is these sorts of impressions that become the part of the culture in a working environment. The expectation of a UOF instructor is to be an ambassador for good practice in the UOF and a role model of someone who exemplifies professional standards and integrity in everything they do. They are key in cascading the core messages from policy and centre rules and to embed into training the necessity for complying with lawful practice, this includes language, terminology and attitudes alongside physical application of force. Recommendation 2 highlights the need for peer observation of training and external quality assurance visits. This will ensure that local training replicates the training manual and the delivery from the national centres. This will avoid local interpretation becoming common practice and local 'we do it this way' mentality.

<u>UOF Incident log 134/17 – D1914[45] - Training, terminology and technique</u>

4.1 I make the following comments in relation to above as referred to at pages 57-79 of this transcript.

4.2 The terminology and description regarding how to use a shield during a planned removal do not reflect training delivered to local Instructors at the national centres. The language used demonstrates an aggressive intent by staff and terms like 'smash and hit with the edge' imply using the shield offensively, rather than its intended purpose as a defensive tool to protect staff during the initial contact. Given the relative confines of a room it is potentially injurious to adopt the technique described by DCM Webb of don't stop, when you hit him don't stop keep going. Once the initial threat has been removed the shield is passed by the officer to a colleague and as it is no longer required.

4.3 Paragraphs 113 and 117 provide my expert description and from the additional information provided it indicates that one of the centres UOF Instructors is cascading incorrect messages to staff, which based on the reference by DCO Martin, have become the norm for some staff. At page 61 para 23 the description of using the edge of the shield anywhere between the knees and throat is also incorrect. The UOF Training manual states on p207 section 8.5- to lace the shield on to the main part of the body; Emphasise body weight of team will assist. Swipe the shield laterally across the person striking the shield to secure the arm with the weapon between the shield and the wall of the cell/room. This is different to what DCM Webb describes.

4.4 I have reviewed the debrief once more and on reflection feel it lacked depth into the force used. DCM Dix did give a narrative of the sequence of events but did not ask the staff involved for any contribution other than if they had any injuries. There is reference to D1914 being

[45] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 page 29.

resistant to start but he then co-operated with staff. Ideally DCM Dix would have outlined his decision making and how the incident was de-escalated. Healthcare contributed very little, and it almost felt that the urgency was to get back to their duties. I accept this was 'hot debrief' and that there may have been a follow up debrief but based on the evidence presented so far this does not appear to be commonplace within the centre.

4.5 At page 70 paragraphs 19-20 Mr Tulley comments that relief for staff during unplanned (spontaneous) incidents was rare. Once sufficient staff arrive the incident supervisor holds the same responsibility for staff as in planned incidents. The responding staff should only be stood down once the incident is under control and no further support is required. Injured or fatigued staff can be replaced, and if it to be a potentially extended and difficult restraint the supervisor can utilise the resources at hand.

4.6 During this incident I cannot see any requirement to replace staff. After the initial effort to apply handcuffs D1914 walks to the CSU with two staff supporting him due to being in handcuffs. There was no physical force required and even if the staff did feel fatigued I observed at least four other DCOs in attendance throughout the move.

4.7 Whenever it has been decided to equip staff with PPE the equipment has to meet the British Standard or EU specifications. Although IRCs do not have to procure from the HMPPS designated supplier the equipment they buy must conform with all standards. For instance, shields must be 4ft, with 4mm polycarbonate and a re-enforced back plate and have BS or EU certification. The supervisor will assess when PPE is required and record their decision on the UOF form.

UOF – Rules for relief to officers following UoF incidents

4.8 I have been asked to advise what guidance is in place for relief to officers following UoF incidents. I am asked to comment upon whether officers were regularly relieved for long UoF incidents and whether there is cause for concern based on the evidence put forward.[46]

4.9 The guidance for managing UOF incidents is within Appendix 2 role of a supervisor. The section titled prior to intervention bullet point 2 describes using support staff if necessary, the section titled during intervention bullet point 4 describe the responsibility for replacing staff, either due to injury, fatigue or staff not using correct techniques.

5.0 It is a managerial responsibility during UOF Incidents to monitor both staff and detainees. If there are any concerns over a member of staff they should be replaced as soon as is reasonably practicable. Even if PPE was issued at the start of the incident there are circumstances where staff not in PPE could take over from a colleague if necessary. With correct de-escalation some items of PPE should be taken off once the initial threat/risk has been removed, for instance if controlling holds, or handcuffs, have been applied and the presence of weapons being used also removed.

5.1 Two incidents do raise concerns over the rotation/replacement of staff. The first incident is Incident 164/17 involving D87. Unfortunately injuries were received by two staff during the restraint and additional staff had been prepared in advance. Paragraphs 326-327 of my report refer to the difficulties staff encountered.

[46] [INQ000098] Callum Tulley Transcript 2 December 2021 page 72.

5.2 The second incident is Incident 135/17 Involving D149. Throughout the incident I observed several examples of poor technique, which could have resulted in injury to the detainee: These are shown at paragraph 61, 62, 64, 66 & 67. Staff could have been rotated or replaced once it was apparent they were struggling with the techniques.

5.3 All other incidents did not demonstrate any signs of fatigue to staff due to the relatively short duration of the restraint. Some of this is down to good examples of de-escalation and the size/layout of Brook House, which means any relocation is over a relatively short distance. I refer to Pages 112-122 in relation to the incident involving D390 on 05.06.2017. I have reviewed the material and have nothing to add on my previous account.[47]

[47] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 pages 61-64 paragraphs 243-264.

2. Reverend Nathan Ward

First Witness Statement [48]

I have reviewed Mr Ward's First witness statement and make the following observations.

UOF – Training

5.4 At paragraphs 226-229 of his First Statement Mr Ward states he was trained as a UOF Instructor, however in his transcript from the hearing at page 178 paragraph 18 note that Mr Ward is not trained in 'Control & Restraint'. I note the vast range of courses and qualifications that he possesses. The issue of force being the first resort leads me to question the quality and oversight of local management. If staff are clearly not using all reasonable efforts to resolve incidents, and not using force as the last resort then this is as much a management failing along with allowing the perceived cultural issues amongst the staff group to develop.

5.5 Paragraph 230 is incorrect in a numbers of the comments. The predecessor to NTRG (national C&R) was in place before the incident referred to. I accept that this incident prompted the development of a wider range of tactics and skills but the training foundation was set up earlier.

5.6 It was, and still is, the intention to utilise the experience from live incidents to provide the back drop to training. In effect staff who carry out operational roles carry credibility to design and deliver training. This is the model that has produced significant success in managing incidents from local level to the most serious of situations which attracted widespread media interests -for instance HMP Manchester (Strangeways) in 1990 through to HMP Birmingham in 2016.

5.7 Para 231 has no direct relevance to the quality of training and is based purely on a personal opinion, he has nothing to substantiate the comments and I strongly challenge the accusations aimed at a wide range of individuals. During the period when Mr Ward attended NTRG sites staff received a number of Director General Commendations and one member of staff received a lifetime achievement award at the Prison Officer of the Year award ceremony.

5.8 I have reviewed Paragraph 232, this was a local issue and was rightly reviewed by the Director and UOF Instructors.

5.9 Paragraph 233 is an out of date review of techniques, many of which have since been revised or removed. Mr Ward talks about an adrenaline rush and alpha male attitude. I remind him that female staff are employed, trained and used during UOF incidents. NTRG have several female staff as do many establishments who also have female commanders and instructors. It is a scientifically evidenced that when involved in conflict the human body releases adrenaline and some people experience natural highs. From my own experience I often observe examples of a post-incident highs where individuals seem to talk louder, with more excitement and energy. This is normally followed by a post incident dip, where staff can quickly become tired and deflated. This experience comes from a professional perspective and

[48] [DL0000141] Reverend Nathan Ward First Witness Statement 10.11.2021.

from a personal perspective within a sporting environment, where similar behaviours occur during heightened adrenaline release.

6.0 The example of Mr Paschali is an extreme and does not reflect the behaviours or attitudes of the majority of staff, I can evidence this from my own experience and many of the incidents I reviewed within this inquiry.

6.1 At paragraph 236 of his statement Mr Ward suggests specialist training for C&R techniques on victims of torture/trauma/serious illness. I agree that training does require specialist input into torture/trauma/mental illness and that it is especially vital for incidents where force has been used or when planning for an intervention where force is possible. In terms of training for crisis management (paragraph 239) I refer to my recommendation 2 in my first report. I highlight the need for a bespoke communication package for staff. Recommendation 1 relates to training the DCM group for managing incidents, this would include dealing with those with specific needs.

6.2 I note at paragraph 243 reference to the comment that a "driver" of "inappropriate uses of force" was the contract which penalised G4S for not presenting a detainee for removal. I am not best placed to comment on the content of the contract but I can re-iterate that force must only be used when all other efforts have been unsuccessful and that there is no other option for staff. There still remains that the justification for force based on the risk.

6.3 I further note that Rev Ward has reviewed various UoF incidents at paragraphs 250-270 of his statement. I make the following comments on these.

6.4 Paragraphs 250-256 relate to an incident involving D2159. In my report at paragraphs 125-133 I share the same concerns as Mr Ward.[49] I do not agree that staff should have worn UOF PPE but accept that protective clothing for hygiene should have been issued. I do not believe using a shield, or applying handcuffs were justified or even ethical.

6.5 Paragraph 257-270 of this statement refers to a UOF involving D1527. This is covered within my report at paragraphs 32-53. I note the comments by Mr Ward regarding the alleged attempts at first aid at paragraphs 266-267. I agree that the methods used do not replicate anything I ever observed during first aid training. For note I have not trained in first/emergency aid since 2016, however I doubt the techniques and advice has changed so dramatically to reflect the actions of DCO Paschali.

6.6 Mr Ward makes reference to possible collusion in report writing. I can confirm that staff should record their UOF independently and that collusion should not take place. I am unable to evidence how reports are completed, for instance in a solitary office, or in a communal area.

6.7 I refer to Paragraph. 435(q) of the statement – Use of recommendations.

p. I have recommended (2) a bespoke package for communication in IRCs. I agree producing a manual version directly for IRCs would also help, but believe that the core content for physical application when used as the last resort remain compatible with other environments.

[49] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraph 125-133

q. Agree that during generic training other areas are covered and that this be delivered by personnel other than UOF Instructors.

s. I think the principles for using force could be gathered centrally but the application in different environments are too wide spread to work cohesively, for instance Policing, Youth Custody, Female Custody, Special Hospitals, IRCs and Prisons.

u. Dr Maconochie has risk assessed the physical techniques within the UOF manual and the HOMES manual.

Reverend Nathan Ward

Third witness statement[50]

I have reviewed Mr Ward's Third witness statement and make the following observations

UOF - Training

6.8 I have reviewed this statement. Mr Ward was not trained or accredited in the restraint system used at Brook House during the investigation period. He did read manual, PowerPoints and asked Instructors to be shown various techniques. This does not amount to formal training, although I recognise his other training and accreditation form other providers. I find it difficult to justify why any senior managers coming from outside of the IRC system would not attend a local initial course at the earliest opportunity after taking up post. As someone who was required to oversee the UOF, and indeed to investigate where necessary, a system he had no formal accreditation within.

Reverend Nathan Ward

Transcript: 7 December 2021[51]

6.9 I have reviewed Mr Ward's transcript and make the following observations:

UOF – Training -Use of de-escalation methods.

7.0 I refer to pages 169-170 of the transcript. As previously stated the requirement for UOF training is 32 hours, which probably equates to one-week of a six-week course. During the remainder of the course there are a number of essential elements of training related to working in a secure environment. I agree with the viewpoint of Mr Ward that more training in communication skills, understanding the effects of custody and de-escalation strategies would be a major step forward. The UOF manual contains information on recognising threats and de-escalating. These are designed to supplement other inter-personal skills training, not replace them. Greater awareness through bespoke training on preventive measures, for instance the regime, information on appeals, and even unit decoration can have an impact on the detainee group- recommendation 2.

7.1 In so far as communication/de-escalation observed during incidents I witnessed some excellent examples, para 334, and some where there was a lack, para 249. It would be a step forward if the centre utilised trained negotiators during planned removals and the strategy

[50] [DL0000225] Rev. Nathan Ward - Third Witness Statement, dated 9.2.2022.
[51] [INQ000101] Rev. Nathan Ward Transcript 7 December 2021.

was set out by the Duty Director. Implementing the process of removing some PPE once the initial risk had been removed should become common practice, and for senior managers to be present during planned removal.

UoF - Training of use of force in an immigration setting.

7.2 I note the response on page 178 paragraph 18 that Mr Ward is not trained in 'Control & Restraint'. My understanding is that all operational staff working in an IRC must at least have been trained in UOF (C&R), although not necessarily refreshed annually.

7.3 The UOF training comprises of theory-based elements and practical skills. It is accepted that the practical skills are the bulk of the training course, but as stated previously the other skills are to supplement other training. In terms of negotiating there is a separate role for negotiation strategies for serious incidents, which should be more routinely utilised at Brook House. This training is designed and delivered by Psychologists and works at building a rapport before persuasion. It is essential that there is an overlap in training so that staff are fully aware that the two work together and are interchangeable throughout an incident. There is no formal training for victims of torture and training in managing people with mental health issues has been slow in development. There is currently work on educating and informing staff on neurodiversity. The medical DVD covers many of the multiple risks associated with restraint along with warning signs and immediate care actions to take.

UoF– Supervision of planned use of force

7.4 I refer to pages 182-183 of this transcript. Based on my observations I do agree that most incidents are supervised by the DCM group. I raise in my report the lack of visible senior managers during incidents, both planned and unplanned. DCMs should not become involved when supervising, although they may apply force during unplanned incidents, but are replaced once staff arrive on scene. In recommendation 1 I state that a DCM must undertake incident scene training before becoming operational in that role.

7.5 At Page 183, paragraph 3 Mr Ward makes reference to completing the UOF report post-incident. The comments from Mr Ward that there is an agenda to cover themselves and justify what they done does not reflect the key messages from training on what is covered in the training presentation for this subject. There is guidance to follow and includes such things as-the build up to the incident, interaction between staff and detainee, behaviour demonstrated, instructions given and attempts at de-escalation. Staff are required to give an account of the force they used-for instance controlling an arm, but this is only part of the overall requirement. My observations led me to make recommendation 7 and paragraph 651 summarise my findings from the evidence presented. I agree that learning from actual incidents is paramount for an improvement in performance and will act to actively address poor practice and identify good examples that should be cascaded to others.

Use of force – Review of reasons for use of force being removals

7.6 I have not been presented with any evidence of a debrief with a detainee following a UOF incident. PSO 1600 lists the requirement to debrief a detainee in order to avoid future incidents of a similar nature and to gather a perspective from the person who experienced force.

7.7 Recommendation 3 and paragraphs 642-644 of my report outline my opinion of the process in place at the time and the measures required to address the clear shortfall in governance and assurance of UOF.

UoF - Inappropriate use of force on mentally ill detained persons

7.8 I refer to pages 185-186 of the transcript. Any specific training for dealing with detainees with mental health issues should be referenced during UOF training and covered during incident briefings. The UOF Training Manual contains very little Information of managing those with mental health issues. This is an area with limited cohesive working and to my knowledge is being addressed in the revised framework and accompanying training manuals.

3. Owen Syred

First Witness Statement [52]

I have reviewed Mr Syred's First witness statement and make the following observations.

UoF training

7.9 I refer to paragraph 58 of this statement. The message delivered by Instructors must constantly re-enforce the general principles for using force and the last resort once all other efforts have been unsuccessful. It would be wrong to assume UOF training is the most important throughout the whole initial course and staff must be provided the adequate skills for all tasks within the defined role of a DCO. All courses that I have observed focus on building relationships and using verbal interaction to resolve difficult situations. If a quality assurance and peer observation process was introduced, recommendation 2, it would assist with addressing the key information from the manual.

UoF - The Role of healthcare

8.0 I refer to paragraph 122 of this statement. The role of healthcare is defined in PSI 30-2015. As stated by Mr Syred they must attend planned incidents and respond to any unplanned UOF. If following an assessment they feel any of the restrictions applied by the force being exerted carry a risk to the detainee they can issue an instruction to either remove or adjust the technique. Staff must follow this instruction and the supervisor of the incident would hold the ultimate responsibility for ensuring the safety of the detainee and acting upon medical advice. However, all staff have a responsibility and if any of those involved, or any on-looker witnesses anything of risk they must inform colleagues involved straight away.

UOF - Concerns involving specific UoF incidents and importance of de-escalation (although not in the RP)

8.1 I refer to paragraphs 157-164 of this statement. The option to utilise all available resources should form part of any de-escalation practice, this will include examples as described of using a member of staff who had built a good rapport with the detainee, seeking support from centre workers or support groups, healthcare, religious leaders and even other detainees. By

[52] [INN000007] Owen Syred First Witness Statement dated 16.11.2021.

not exhausting all reasonable options it is impossible to justify using force as the last resort. If a process as listed within recommendation 3, which would give the review committee the opportunity to review UOF reports and examine for evidence of complying with the lawful application of force. It is concerning that the matter was not discussed when raised by Mr Syred at a meeting with managers.

Owen Syred

Second Statement [53]

8.2 I have been provided with this statement and have reviewed the same. I have no comments to make upon the same.

Owen Syred

Transcript: 7 December 2021[54]

8.3 I have reviewed this transcript and make the following observations.

UOF - Appropriateness of Use on E Wing

8.4 I refer to pages 56-58 of the transcript. I have experience of CSUs being used for multiple reasons, including those who need additional support, those who are unable to cope-for instance being bullied on the mainstream units, and for disciplinary purposes. I have learnt through operational experience and reading evidence from this inquiry that removal flights can at times require the detainee to be collected during the night/early hours. If there is a risk that the detainee will become non-compliant I understand local protocol is to remove them the night before.

8.5 The evidence from the removals on the units demonstrate this does happen to avoid it becoming disruptive to the regime and those on the unit. With limited facilities within the centre for locating all of the different groups the use of one CSU may be the only option. I agree that mixing those with different needs and reasons for location within the CSU is not a perfect solution and it requires a contrast in skills from the staff, ideally bespoke staff would be assigned to look after those in need of care.

UOF – Necessity and reporting

8.6 I refer to pages 123-126 of the transcript. This describes an incident where there was an unnecessary and excessive UOF with a technique not prescribed in training. The failure to report this incident and the reasons for not reporting validate my recommendation 9-reporting wrongdoing. It is concerning to read that the thought process was of being ostracised and had no trust in the system or nothing would be done, and he would be thought of as a troublemaker.

8.7 Staff must have faith in the system and not to fear retribution from colleagues. The use of BWVC, in line with the policy, would be a major step forward in eradicating this kind of behaviour, especially when knowing cameras are being activated immediately the response call is sent out.

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[53] [INN000010] Second witness statement of Owen Syred dated 1.12.2021.
[54] [INQ000101] Transcript: Owen Syred dated 7 December 2021.

4. Ioannis (Yan) Paschali

(i) First witness statement of Ioannis (Yan) Paschali [55]

8.8 I have reviewed Mr Paschali's First witness statement and make the following observations.

UOF - Staffing and Reporting procedure

8.9 I refer to paragraph 11 of this statement. It is within policy that all staff complete a UOF report following any force used. Expecting staff to complete the report on the wing carries several concerns, the likelihood of collusion, being interrupted and completing it quickly and without significant detail due to the demands on the unit and the inability to carefully reflect and recollect the events. Ideally a place away from the unit would be suitable and staff should be given time to compile their reports. When considering the importance, for example with this Inquiry, of accurate report writing the failure to provide suitable time and location for competition rests with the senior managers.

9. Whilst I understand why the use of some staff for all planned removals takes place, for instance experienced and competent individuals, it does carry several risks. Other staff who do not receive exposure to incidents of this nature can on the occasions, when there is no alternative but to use them, lack confidence and are devoid of leadership and direction from experienced colleagues. There is also the mental and psychological impact on individuals used regularly.

9.1 All completed UOF documentation must be collated by the incident supervisor and logged and stored as directed in PSI 30-2015.

9.2 I have previously noted that within the footage I observed and in the UOF documents there was a lack of senior managers. PSO 1600 and the UOF Training Manual identify senior managers' responsibility within the role of the supervisor section.

UOF - Training

9.3 I refer to paragraph 32-33 of this statement. I would expect that most of the UOF training Mr Paschali received from G4S would have been the same as what he received from HMPPS.

UOF – Staffing levels

9.4 I refer to paragraphs 60-65 of this statement. I do not have details of the contractual staffing requirement or the regime staffing levels. Most of the incidents I observed had sufficient staff in attendance, but this would not necessarily reflect staffing on the units when the normal regime was in operation. Under normal circumstances if the Minimum Staffing Level (MSL) was not achieved a management decision would identify a reduced regime using a Regime Monitoring Plan (RMP).

[55] [IPA000001] First Witness statement of Ioannis Pascali dated 17/01/22

UOF – General Comments

9.5 I refer to paragraph 75 of this statement which raises a valid concern about becoming desensitised to incidents. I have no knowledge of the staff support mechanisms at Brook House during this period. Where staff are subjected to potentially stressful and emotional working practices, such as acts of self-harm, UOF, dealing with those who have experienced trauma or torture, there is a duty on the employer to offer suitable care.

9.6 I appreciate this comes in many forms and it should be explained to staff during their induction/initial training and re-iterated through posters, staff newsletters etc. Post incident debriefs should also form part of the care plan, both within the hot debrief and the cold debrief, if such debriefs takes place. Line managers should also be able to refer staff for expert support if through their conversations it becomes apparent that the member of staff is experiencing problems.

9.7 I refer to paragraphs 78-29 of this statement. Mr Paschali appears to understand the lawful and appropriate circumstances when force can be used.

Abuse of detainees.

9.8 The evidence I have been presented with would substantiate that no evidence was presented of acts of violence, as described by Mr Paschali, except the incident number 105/17 involving D1527, detailed at paragraph 32-53 of my first report.

9.9 I disagree with the comments at paragraphs 95-96 of this statement, that using some of the terminology and language was staff just letting off steam. I have previously commented on what can happen following exposure to conflict, but there is a line and some of what was said should be challenged, for example paragraphs 265-266 involving D275.

Ioannis (Yan) Paschali

(ii) Second witness statement [56]

UoF Incident – D1527 25.04.2017

Assessment of Reasonableness of use

10. I refer to paragraph 27-36 of this statement. Whenever a UOF is assessed the whole situation, including events prior to force being used, the restraint itself, and the actions of the detainee would be among the considerations. It is accepted that a restraint situation will not always mirror what takes place in a training environment and staff have to judge the incident on its own unique factors. In my response to Mr Ward's description of emergency aid I confess to not being an expert in this field and have received training back in 2016. There is no guidance within the 2015 version of the training manual on who to either forcibly remove an object from the mouth, or how to prevent swallowing an object in the mouth. I did not hear any dialogue from Mr Paschali during the incident involving D1527 that indicated he was attempting to prevent swallowing and the pressure on the throat was for this reason.

[56] [IPA000002] Second Witness statement of Ioannis Paschali 17.01.2022.

Communication between staff and detainee, and staff to colleagues, is vital so that all parties understand what is happening and what needs to be done.

10.1 The incident that I reviewed for the Employment case at Full Sutton Prison, referenced in Mr Pascali's statement at paragraph. 34-35 was very different to the incident in question. Each UoF incident has to be assessed on its own merit and has to be assessed depending on each of the circumstances, including the fact that Full Sutton is a category A High Security Prison, which is a vastly different environment to an IRC. I believe my expert opinions have been used out of context.

UoF incident re D2559 on 27.04.2017[57]

10.2 I refer to paragraph 49 of this statement. There is insufficient evidence to allow any further comment on the appropriateness of force or how the redness to the take occurred.

UoF incident re D2389 on 09.04.2017

10.3 I refer to paragraph 50 of the witness statement which refers to the above incident. I did not review this incident in my first report and I confirm I have nothing I can add.

UoF incident re D1020 on 10.05.2017[58]

10.4 I refer to paragraph 51 of the witness statement which refers to the above incident and confirm there is no further evidence to change my initial opinion.

UoF incident re D1523 on 17.05.2017

10.5 I refer to paragraph 52 of the witness statement which refers to the above incident. I did not review this incident in my first report and I confirm I have nothing I can add.

UoF incident re D1914 on 27.05.2017[59]

10.6 I refer to paragraph 51 of the witness statement which refers to the above incident and confirm there is no further evidence to change my initial opinion.

UoF – Training

10.7 I refer to paragraph 78 of the witness statement. The description does not relate to the training in UOF. When faced in isolation and with a threat of harm staff must attempt to either use verbal persuasion or look to exit to a place of safety. If all of these options are not available and the member of staff feels at an imminent risk of harm the use of a pre-emptive technique can be a consideration and used under Common Law. This is not to say all perceived threats can be dealt with in this way. Staff must still apply the general principles before using force. PSI 30-2015 includes details of judging pre-emptive strikes, decision making and Common Law.

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[57] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 553-557.
[58] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 536-540.
[59] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 97-124.

UOF – Technique

10.8 At paragraph 103 of this statement Mr Paschali states it is his understanding of how the shield is used. I can confirm that my previous descriptions and explanations are from the training manual which differ from those explained by staff, including Dave Webb and Yan Paschali, at the time. In his previous statement he said that he could not remember the UOF training but in this statement he seems sure of the shield technique.

UOF – Staff attitudes

10.9 I refer to paragraphs 108 and 113-114 of the witness statement relating to staff comments made regarding the assault of detained persons off camera. The comments may have been made in a light-hearted manner but they can influence younger staff and give them a misguided impression of how professional practice is applied when using force.

11. Within my statement to the Police Mr Paschali refers to a description of the Mandibular Angle Technique. I was asked about this technique by the investigating officer and asked to consider if that was what Mr Paschali was attempting to use. At no time did I say that was what he was using, I do not recall why the police asked for me to consider it but I do recall having a conversation about the MAT as the police use the same technique.

11.1 Mr Paschali uses the Criminal Justice & Public Order Act 2008 as the legislation that authorises force to be used. Whilst the legislation is accepted as authority to use force it does still require staff to be accountable for their actions and for staff to evidence force was necessary and proportionate. Within a custodial setting the Act would apply more to personal safety or unplanned incidents (at the early stage) as opposed to incidents where sufficient staff are in attendance and the detainee is under control.

5. Derek Murphy

(i) First Witness Statement[60]

UOF – Planned Incidents

11.2 I refer to paragraphs 22-48 of this witness statement. In relation to debriefs being only for planned incidents this is incorrect. There should be a debrief after any UOF incident, including unplanned.

11.3 Good practice would be to allow staff some respite after a UOF Incident, especially if it had been a difficult protracted situation, or if staff received injuries. It should also be a consideration of the mental and physiological impact a restraint can have on staff. I am conscious of the requirement to return the regime to the normal operating mode but staff care post-incident must be factored into the decision making of managers.

11.4 It concerns me that a replacement team were not available for the incident on 28th March 2017, even more so due to a carry technique being necessary.

11.5 The incident referenced in paragraph 41 involving D1747, 158/17 is incorrect when describing using open palms. The footage clearly shows a push with the fist clenched. My initial opinion

[60] [INQ000121] First Witness Statement of Derek Murphy dated 6.2.2022.

remains that despite being with clenched fists the action was a necessary push in order to create distance.

Derek Murphy

(ii) Witness statement of Derek Murphy Annex A[61]

UoF generally

11.6 I refer to Paragraph 57 of this statement which appears to highlight that post-incident reviews never took place and that Mr Murphy was not even aware of the phrase 'lessons learnt'. This should be a regular occurrence, especially after some of the more complex restraint incidents. If as he states force was used daily this should have been flagged by both senior managers within G4S and the Home Office. More alarming is the indication using force daily was almost expected and that staff became accustomed to using force as part of the normal working day, when in fact it should be a rare and exceptional occurrence.

11.7 If a fully functional review process was in place, including representation from all interested parties, the amount of UOF incidents would have become apparent.

6. Nathan Harris

Witness statement[62]

Use of Force – Planned and Unplanned Incidents

Incident 07.06.2017 re D672

11.8 I refer to paragraphs 76-85 of this statement which refers to the incident on the 7 June 2017. It was not a factor who removed the joggers but the how. Paragraph 82 is vague as to if staff were wearing BWVC, and this is consistent with many incidents during this period when the activation of BWVC did not take place despite staff being in possession.

11.9 Paragraph 80 indicates that Mr Harris regarded the incident as unplanned. I stand by report comment that it should have been a planned incident due to the number of staff in attendance and no immediate necessity to use force.

7. Nathan Ring

First witness statement[63]

12. I refer to paragraph 24 of Mr Ring's witness statement. The question (g) relates to MMPR which is a restraint system used within the under 18 year old estate and is not applicable to Brook House.

[61] [INQ000113] Witness Statement Derek Murphy - Annex A dated 21.01.2022
[62] [SER000432] Witness Statement of Nathan Harris dated 23.01.2022.
[63] [MIL000002] First Witness statement of Nathan Ring dated 27.01.2021.

Nathan Ring

Second witness statement[64]

UoF training.

12.1 I refer to paragraph 2 of this witness statement. I have no comment to make other than this is a broad explanation provided by Mr Ring.

(UOF incidents)

UoF incident on 07.03.2017 re D3548

12.2 I did not review this incident in my first report. I refer to paragraphs 14-18 of this witness statement. The content of the response from Mr Ring confirms my opinion that staff from the Home Office should attend when a removal order is being carried out. The staff from Brook House are unable to answer questions regarding an appeal and are instructed to ensure the removal takes place.

12.3 This was another incident where the detainee was undressed. Consider the number of incidents of this type I have made comments in my first report that I find it strange that G4S did not investigate some sort of gown for instances of this type.

UoF on 20.04.2017 re D489[65]

12.4 I refer to paragraphs 19-24 of this witness statement. My conclusions are supported by paragraph 20 from Mr Ring's statement confirming the Home Office gave authority for force to be used if necessary. The policy document authorising force is DSO 15/2012, paragraphs 9-10. I am satisfied that the force used was the minimal required for the task of lawfully taking fingerprints.

UOF on 25.04.2017 re D1527[66]

12.5 I refer to paragraphs 25-40 of this statement. My conclusions remain the same. There is confirmation of comments made that are not appropriate, even when out of hearing distance from the detainee involved. There is a reference to the environment within a custodial site, and the type of language and comments made. In order to professionalise staff training and education should be provided to demonstrate how staff should interact as custodians and move away from the almost accepted use of industrial language when addressing detainees.

UOF on 27.05.2017 re D1914[67]

12.6 I refer to paragraphs 45-48 of this statement. There is no mention in the statement of the use of a shield or descriptions by staff on how a shield should be used. Para 48 states that minimal

[64] [MIL000001] Signed Second Statement by Nathan Ring dated 25.01.2022
[65] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 546-552.
[66] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 32-53.
[67] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 97-124.

force was used. I stand by my initial opinion that force was not necessary at the time and more efforts at persuasion and negotiation should have taken place.

12.7 My overarching view of the DCM group during situations when a planned removal takes place Is that they give a couple of chances to comply and then resort to force. Correct training, as per recommendation 1, would include how to explore all reasonable options and how to escalate a situation if the detainee is non-compliant to the instructions. This is the point when a senior manager should become involved and liaise with the DCM, and any other relevant staff, to find a solution. It is accepted that on some occasions force will be required but there is little to demonstrate it is actually used as the last resort.

8. Graham Matchett

Witness statement[68]

UoF generally

12.8 I refer to paragraph 8 of this witness statement. The comments relating to BWVC does explain their introduction and what they achieve. The comment that they protect staff could be mis-leading. BWVC footage can be used in cases where a complaint or concern has been raised. Their use is part of a safety initiative and is correct in saying that it provided reassurance to detainees that staff actions are recorded. They do assist in de-escalating a situation, but the tone and manner of verbal interaction must remain non-threatening.

12.9 There is no set number of instructions or orders given before force is used. Each incident must be managed based on its own unique circumstances and force only used when all reasonable efforts have been tried and been unsuccessful, and when there is an imminent risk of harm or for potential disorder. Mr Matchett is correct that there will be occasions when no order is given, or when staff have to intervene immediately.

(UOF Incidents)

UoF incident against D2830 on 10.07.2017[69]

13. The incident described by Mr Matchett at paragraph 10(b) of his statement is not incident 174/17.

UoF incident against D720 on 05.06.2017[70]

13.1 This incident is referred to at paragraphs 24-31 of Mr Matchetts statement. My conclusions remain as there is no evidence to alter my original opinion.

[68] [BDP000001] Graham Matchett First Witness Statement dated 10.01.2022.
[69] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 509-516.
[70] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 593-597.

9. David Webb

First witness Statement [71]

UoF – Planned

13.2 Paragraph 57 of this statement mentions that incidents were all filmed and reviewed. Other than the tick box check by DCM Steve Webb I have no evidence to support the effective reviews of incidents took place, evidence would include TOR, meeting minutes, lessons learnt etc. The incident referenced was resolved using minimal force. As an instructor I would expect a fuller description of the techniques used, how they were de-escalated and the relocation.

Annex B to statement of David Webb[72]

Use of Force

13.3 The comment made at Paragraph 7 of this statement is correct. As the shield officer the member of staff then takes up the role of the head support officer once the shield is no longer required. At paragraph 12 of his statement Mr Webb states at the time (May 2017) he believed his description was correct for the use of a shield. It would be useful if he still held that view after qualifying as an instructor in August 2017?

Training

13.4 I refer to Paragraph 22 of this statement. When conducting role play scenarios I can confirm it is commonplace for the person playing the part of a detainee to use language and demonstrate the behaviours likely to be experienced by staff when carrying out their duties in the workplace. Training must expose staff to situations that replicate real life and must be designed to allow the student to develop their methods for controlling such incidents. Reviews after training are essential to identify good practice and address areas for improvement.

13.5 When demonstrating a scenario the Instructor must demonstrate the role model of a good DCO. The language used must be suitable for the situation and remain within the professional standards required of all staff. For instance remaining calm, not being threatening, using open ended questions etc

13.6 If in this case Mr Webb used the language "I'm going to fucking destroy you" in the role of a DCO this would not be appropriate and rightly subject to disciplinary measures.

10. John Connolly

Witness statement (undated)[73]

UoF - Training

13.7 There is a job description within the UOF Good Governance Toolkit. Previously the role would vary between establishments, depending on the time allocated for the task and the scope of the role. By issuing clear guidance we hope to standardise the role across all sites and improve

[71] [INQ000114] First Witness Statement of David Webb dated 02.08.2021.
[72] [INQ000131] Annex B to Witness Statement of David Webb dated 12.02.2022.
[73] [INQ000120] Witness Statement by John Connolly, undated.

the oversight in UOF. The role does also require arranging training for staff, maintenance, and procurement of PPE, and supporting the command suite during serious incidents.

13.8 The removal of the UOF coordinator role may have been misguided. A possible option would have been to create a part-time post in order to maintain some consistency and oversight. Within my first report I have raised my concerns over the 'tick box' review process in place at the time. It was not sufficient and it failed to identify a number of issues which would have been clear to a trained Instructor when reviewing the footage.

13.9 I do find it unacceptable that the Director at the time, who had not previously been trained in the HMPPS system, did not attend the UOF training course. This is similar to what has been identified with Mr Ward, who came from the same background. To have credibility my opinion is that all managers must have been trained, but not necessarily refreshed, unless any major changes have taken place, an example would be for all senior managers to attend the SPEAR personal safety training which is now being rolled out.

Para 30 (b) - This is an incorrect explanation of a situation when the detainee either assaults staff or initiates force. Staff are still expected to avoid using force and there are numerous options they can consider (outlined in PSI 30/2015), examples would be step back and summon assistance or create physical barriers, withdraw from the scene, or engage with an attempt to prevent further violence and to de-escalate. It has to be accepted that in the most violent of assaults staff do have to act instantaneously and the option of trying to de-escalate is not possible initially.

14. In paragraph 31 Mr Connolly confirms that whilst in the staircase for the incident involving D275 there was conversations about previous incidents. The issue with using almost 'bravado' attitudes is that it can easily influence younger inexperienced staff, especially when coming from someone of experience and who is a local Instructor. This is not effective role modelling and would almost create the mindset that staff are expected to act and behave in the ways described in order to gain some form of credibility amongst their peers.

John Connolly

Witness statement 26.08.21[74]

14.1 I refer to paragraphs 1-3 of this statement. During the investigation period the reviews of UOF incidents were carried out by DCM Webb. Mr Connolly did not review incidents during this time.

14.2 I refer to paragraphs 57-59 of this statement. During many of the incidents that I reviewed BWVC were not activated during unplanned incidents, even by the DCM group.

14.3 I note the opinion of Mr Connelly on issuing all staff with handcuffs (ratchet version). The introduction of Rigid Bar Handcuffs (RBH) into the UOF curriculum has now been implemented. At the time there were seldom any occasions where a DCM did not attend an unplanned incident in a timely manner. Therefore I cannot comment on the opinion expressed by Mr Connolly. Early feedback from the addition of RBH has been positive, although no data

[74] [INQ000124] Witness Statement of John Connolly dated 26.08.21

analysis or reviews have taken place so far to judge their effectiveness in resolving incidents quicker and with less injuries.

11. Shane Farrell

Witness statement[75]

UoF incidents

14.4 I have reviewed the use of force incidents at paragraphs 56-57 of this witness statement. The incident involving D1538 involved Mr Farrell applying the head support position as he describes in paras 63-64. I can confirm that UOF training involves three staff to restrain a detainee. One of these is the head support officer. Once control is gained the head support can be released, normally after handcuffing or if restraints are released or de-escalated. In this incident the head support was momentarily applied then released and then re-applied. My report at paragraph 418 outlines my assessment and opinion of the use of the head support.

12. Kye Clarke

First witness statement[76]

UoF - Training

14.5 I note paragraph 30 mentions that training could not prepare new starters for the real life in the centre. My recommendation 6 covers scenario-based training. Any restraint system must include an element of reality and to try and replicate real scenarios. This is difficult against the wide range of possible situations, but at least some form of 'pressure testing' training would assist in giving staff a chance to understand what working at the centre can entail.

14.6 Paragraph 37 also makes reference to a set number of warnings before force was used. In my experience I have never observed such an instruction or has there ever been a set number. Each incident is based on its own unique circumstances and the number of warnings impossible to set in advance.

14.7 Paragraph 69 relates to an incident covered in my first report. There is no further information provided to change my initial assessment.

[75] [SER000433] First Witness Statement of Shane Farrell dated 29.01.2022.
[76] [INN000012] First Witness Statement of Kye Clarke dated 27.01.2022.

13. Slim Bassoud

Witness statement [77]

UoF

14.8 I note Paragraph 16 refers to staffing levels. Whilst I accept the concerns, my observations of incidents prove that response staff generally arrived in high numbers if a general alarm was activated.

14.9 I have reviewed paragraph 37 and they give a broad account of UOF training. I have nothing further to add.

15.0 I note that Paragraph 59 explains the correct procedure for healthcare during both planned and unplanned UOF. I also note in Paragraph 87 the terminology by Mr Webb, namely saying "If you do not stop screaming you will feel more pain" (27 April 2017 against D191), is not constructive de-escalation and could easily be deemed threatening. There is a correct protocol for using a PIT where the member of staff gives a clear indication of what is expected, a chance for the information to be processed by the detainee, and a final order. The terminology should not be aggressive and should be delivered calmly but assertive.

14. Steve Dix

First witness statement[78]

UoF

15.1 I refer to Paragraph 17 of this statement.- I have recommended (1) that DCM receive better training when they take up the position. I am of the opinion this was a major failing at the time and do not that the centre now pays more attention to recruitment and training of DCMs.

15.2 Paragraph 22 relates to the introduction of the SPEAR system to replace the former personal safety package. Paragr1aph 23 confirms DCM Dix is now an instructor at the centre. It is good to have DCMs within the Instruction team as they can cascade policy and technical advice to less experienced staff during incidents. Correct procedures are highlighted in paragraph 41 for the role of healthcare during incidents. I can confirm that the UOF training manual did not include any specific guidance on dealing with detainees with mental health issues at the time of the investigation. This is being addressed and the intention is to include some guidance in the renewed framework due for implementation in May 2022.

[77] [SER000435] First Witness Statement of Slim Bassoud dated 03.02.2022.
[78] [SER000436] First Witness Statement of Steve Dix dated 03.02.2022.

Steve Dix

Second witness statement 03.02.2022[79]

15.3 I make the following comments on this statement. Whilst it is reassuring that Mr Dix now understands that handcuffing whilst seated is not appropriate and should not be used it does concern me that this information was not cascaded sooner to the staff group.

15.4 Mr Dix identifies the problem when dealing with naked detainees, which seemed at the time to be a regular issue. I have previously reported that some form of smock should have been considered, rather than trying to hold a towel around the waist.

15.5 The incident involving D1914 states Mr Dix raised concerns regarding using force on D1914, however there is no record of this. In this situation he could have recorded his concerns on his BWVC as evidence of the conversation. He stated that D1914 was particularly aggressive, but when viewing the footage he did not appear to be offering any threat to staff or any aggressive behaviour. He does not explain why staff used the shield and why force was used after it became apparent D1914 was not offering any form of threat to staff.

15.6 Mr Dix gives a similar opinion to myself regarding the incident involving D1978 when the team entered the room and restrained D1978 after he appeared to be complying with the instruction from Mr Dix. He accepts there was a misunderstanding that resulted in the staff entering and using force.

15.7 Throughout his statement Mr Dix acknowledges failings in completing reports and his understanding of procedures for document collation post-incident.

15. Shane Munroe

First Witness statement [80]

15.8 I note at Paragraph. 57 the witness make a comment about John Connolly. The comment made by Mr Connolly of "this was excellent because they did not get many 'udder swingers' showing an Interest in becoming UOF instructors" was not appropriate and demonstrated a lack of understanding of how comments like this are demeaning to staff. I do note however that Mr Connolly did appear to welcome the interest shown to become an Instructor, despite the inappropriate terminology used.

16. Ben Shadbolt

First Witness statement[81]

15.9 I refer to Paragraphs 108-211 where Mr Shadbolt accepts that the handcuffing technique used on D2054, 162/17, has now been removed and any handcuffing from the supine position

[79] [SER000437] Second Witness Statement of Steve Dix; 03/02/2022
[80] [INN000013] First Witness Statement of Shayne Munroe dated 07.02.2022.
[81] [SER000441] First Witness Statement of Ben Shadbolt dated 10.02.2022.

should only be used once the detainee has been stood up or from a kneeling position. There is no additional evidence to alter my opinion of the incidents I reviewed within my first report.

17. Jordan Rowley

Witness statement [82]

16.0 I refer to Paragraphs.47-65 of this statement. The issue raised concerning completing a UOF report at 10pm, after a shift was due to finish at 9pm, is in my opinion not conducive to correctly reporting the details form the individual officer's perspective. I understand the contractual requirement is for all reports to be submitted within 24 hours. This differs from HMPPS where reports must be submitted within 72 hours. This is a major difference between the two agencies. My opinion is that 24 hours is not sufficient time for a member of staff to recollect their thoughts on the incident and to articulate these into a report. At times when fatigued the quality of the report will inevitably be reduced, resulting in an inaccurate statement of the facts. When considering that the DCO would rely on this report several years later, and potentially in Court, I find it difficult to understand the gulf between the Home Office and HMPPS.

16.1 No information has been provided to alter my finding or opinion on incident 81/2017 involving D1234 or incident 86/2017 involving D2159. I have not reviewed the incident involving D1765.

[82] [SER000438] Witness Statement of Jordan Rowley dated 06.02.2022.

C2. Healthcare Staff – Witness Evidence to the Inquiry

1. Michael Wells (Senior Practice Manager at Brook House and Tinsley House)

Witness Statement[83]

UOF - Health care staff training

16.2 I refer to paragraph 19b of Mr Wells witness statement in reference to the Violence Reduction Strategy.[84] All non-uniform (or described as non-operational) staff should receive training in personal safety when they are likely to work or come into contact with detainees, this includes healthcare staff. In addition to the personal safety training healthcare staff should receive training or guidance on their role during UOF incidents, all of which is outlined in PSI 30-215 and the UOF Training manual.

2. Sandra Calver (Head of Healthcare)

Witness Statement[85]

UOF Incidents - Role of Healthcare

16.3 An explanation of the role of healthcare is referred to at paragraphs 148-150 of this witness statement. The only concern I have is the revised process of waiting for a couple of hours after an incident to check on the detainee ad detailed at paragraph 149. This must be removed and return to checking, as best they can, straight after the incident. It is accepted that at times this may not be possible due to a number of factors, including the behaviour of the detainee at the time. If a full check is not possible straight away it should be recorded on the F213, and updated when an assessment has taken place.

3. Dr Oozeerally, GP, Immigration Healthcare

Witness Statement [86]

UOF – Training

16.4 Dr Oozeerally makes reference to UOF which includes C&R and personal safety. This is correct in accordance with the Violence Reduction Strategy (CJS000721)

UOF - Role of Healthcare

16.5 I refer to paragraph 103 and 104 of Dr Oozeerallys witness statement. Although the Doctor may not complete the F213 they could add to any comments if they examine/assess a detainee post-incident. With reference to Paragraph 112 I confirm all staff are expected to

[83] [DWF000004] Witness Statement of Michael Wells Senior Practice Manager at Brook House and Tinsley House dated 5.11.2021
[84] [CJS000721]
[85] [DWF000009] Witness Statement of Sandra Calver (Head of Healthcare, Head of IRCSs) dated 9.11.2021.
[86] [DRO000001] Witness Statement of Dr Husein Oozeerally dated 30.11.2021.

report wrongdoing, regardless of whether they were G4S, or now Serco. This is as per Recommendation 9 of my first report.

C3. Formerly Detained Persons Witness Evidence to the Inquiry

Note on Records - Medical and detainee records

16.6 For the sake of clarification, I confirm I had no information on the medical health or vulnerabilities of any detainee involved in the incidents I reviewed. I did have information that on some occasions the detainee had self-harmed. Therefore they have not been factored in to my findings.

16.7 Furthermore, at Paragraph 4(i) of my first report the reference to detainee records are specific to the Use of Force (UOF) documents for the related incident. It does not include personal information of any kind as my instructions focussed primarily on the UOF. The only documents I reviewed are the UOF forms, incident review and any complaints investigations by PSU.

16.8 I have reviewed the following additional statements and add my comments upon the same.

1. D1527

Witness statement[87]

Incident 24.04.2017 (D1527)[88]

16.9 The account given in paragraph 46 states that the officer told him to go to E wing with him or they would drag him is not the kind of language or means of gaining compliance expected of staff. The removal of the two roommates would raise a concern to the detainee. I appreciate why staff do this but it should only be after all reasonable efforts to gain compliance with the move had been attempted. The comment that once he learned how awful E wing was he never wanted to go again. He gives an explanation of what it was like in paras 24-27 that made E wing so awful and it appears any future attempts to remove him would result in him resisting the move. Incident 104/17 was reviewed within my report but not fully as it was within the second set of incidents. I did not review any footage and the staff statements focus on force being used to prevent self-harm. D1527 refused to be assessed by healthcare following the incident.

17. My initial report only covered the force used to prevent self-harm and not the removal to E wing. My opinion of the restraint remains.

[87] [DL0000144] – D1527 Signed Witness Statement dated 19.11.21

[88] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 518-524.

Incident 25.04.2017 (D1527)[89]

17.1 Due to the lack of footage I am unable to comment on the events after DCM Loughton cut the ligature. My comments regarding the UOF summarised in paragraphs 48-52 of this statement remain.

Incident 04.05.2017 (D1527)[90]

17.2 At paragraph 276 of my report I noted that D1527 was removed from the room stood upright and in handcuffs. D1527 claims he was dragged to E wing (paragraph 276) and that DCO Shaukat had hold of his head. This may have been the case in the room but not once on the landing. The removal downstairs would include the head support being applied in order to prevent injury.

17.3 Paragraph79 is incorrect in the belief that once staff apply a restraint thy have to keep holding you. Staff can be replaced or interchanged at any time and for a number of reasons. In my report at paragraph 277 I note that a change of DCM Yates took place and according to the staff reports this was due to D1527 focussing his anger toward DCM Yates. The pain felt on one hand was due to DCM Yates applying a thumb lock. I refer you to paragraph 273 of my first report which sets out the correct procedure for applying a PIT.

17.4 It is clear D1527 has a different viewpoint to the staff regarding this incident. I can only base my opinion on the footage available, which I criticise due to no BWVC activation, and the staff reports. There is insufficient evidence to cause me to change my opinion. My only concern is that a PIT technique was used when handcuffed and the lack of information provided by DCM Yates. This would have been the one point where I would have to consider the proportionality and necessity of force for that part only.

2. D2033

Witness Statement[91]
Transcript: - 10 December 2021[92]

17.5 This is my first review of the evidence given by D2033 and I make the following observations on the transcript.

<u>UoF incident by TASCOR.</u>

17.6 At page 123, paragraph 18 of this transcript D2033 states officers had batons and shields. Batons are not authorised for planned interventions and are not issued to Brook House staff. At page 124, paragraph 1 D2033 mentions that other staff wearing black uniform took over and escorted him to Germany. He also states that these staff placed him in a WRB. The decision to apply the WRB would be based on the risk presented by the detainee and to ensure the removal order was completed. Once applied the WRB can be adjusted to de-escalate the

[89] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 32-53.
[90] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 268-294.
[91] [DL0000149] Witness Statement of D2033 Witness Statement dated 19.11.2021.
[92] [INQ000104] Transcript: - 10 December 2021

situation and allow more freedom with the arms, for instance to eat/drink. If a detainee is disruptive, or offers resistance to the move, staff can apply pain inducing techniques (PIT), but only when all other efforts have been unsuccessful and when the correct protocol for use is applied.

17.7 Use of a PIT through the handcuff is within the training manual, but as with all handcuff techniques additional care must be applied to avoid the possibility of a wrist injury. The description on page 125 is accurate on the seating arrangement of staff during the flight. The prolonged use of the head support would be unusual, but as with all force the staff must record their justification for the continued use of any force, and when force is no longer necessary it must be removed.

3. D668

Witness statement[93]

Transcript: 6 December 2021[94]

17.8 At paragraphs 39-45 of his witness statement D668 describes the use of force against Jonathan as reasonable, justified and used as a last resort. I can only comment on what should have happened in context of the description from D668. If DX had refused to pack his personal possessions and refused to comply with their instructions for removal on the charter flight, force could be used as the last resort under DCR 43 paragraph 10. As previously stated a decision should be made on whether to equip staff with PPE for any planned removal. I note the reference to face coverings, if this was balaclavas I can confirm that they are not authorised for local planned incidents. I would be surprised if a solitary member of staff entered the room in the first instance.

17.9 Normally I have observed conversations at the door before the team are deployed. In paragraph 41 it is said that DX was naked but in paragraph 42 it is said that his top was naked. The reference to handcuffing in paragraph 42 could be either handcuffs or the application of a WRB. The reason I state the latter is that leg restraints are often applied with a WRB when necessary. It would be justifiable for handcuffs but a WRB would only be applied by escort staff (Tascor at the time) and normally in the discharge area and from my observations not in residential areas.

I have no comments to make on the transcript.

[93] [DL0000153] First Witness Statement of D668 dated 22.11.2021.

[94] [INQ000100] Brook House Inquiry - Live Evidence Transcript; 6 December 2021

4. D1713[95]

Witness statement

Transcript: - 10 December 2021,

UoF incidents.

18.0 I have reviewed this statement and am unable to comment as there is no evidence of the force used, only that force was used. I have reviewed the transcript and have no comment to make.

5. D1851

Witness Statement[96]

Incident date: 05.06.2017

18.1 My conclusions in my report at paragraphs 259-264 remain and the evidence provided will only go to confirm my opinion.[97]

18.2 With regard to the use of force against D1851, if as described in paragraph 42 of his statement two shields were used to pin D1851 down, one on his chest and one on his legs and this would in my opinion be excessive and not within training guidelines. My report focussed on D390 and my opinion of the UOF used on him, not his roommate. Any force used must be recorded, including the force described. The staff would have to justify their decision against the risk presented by D1851. Without any documents there is no evidence to form an opinion on the general principles being applied and whether the force was justifiable.

18.3 D1851 refers to the D274/D275 UoF incident at paragraphs 48-51 of his statement. I did not comment on this incident within my report. I was asked to comment on behaviours and attitudes of staff during the course of the incident.

D1851 Transcript: 3 December 2021

18.4 At Page 96 paragraph 14 D1851 makes reference to D390 stating he was hit by batons. No evidence is available to support this claim and the use of batons are not permitted for planned interventions within any custodial setting. The use of a shield was temporary after staff made contact, after which the shield was removed. Paragraph 244 gives the justification for my opinion in paragraph 253 to prepare for a planned intervention. Paragraph 256 forms the basis for my opinion that force was used before it being a last resort and without one final attempt to persuade D390 to comply once the room door had been opened.

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[95] [BHM000018] Witness statement of D1713 dated 9.12.2021.

[96] [DL0000143] Witness Statement of D1851 dated 19.11.2021.

[97] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 259-264.

6. D1618

Witness statement[98]

UoF Incident 29.07.2017

Q. Paras. 39-58 – UoF incident on 29.07.2017 – removal by TASCOR.

18.5 At paragraph 78-81 there is reference to a complaint. I confirm I am unable to comment on the complaints process or the content of the complaint.

D618 Transcript: 3 December 2021[99]

18.6 At page 19 paragraph 17, D1618 refers to the use of the Waist Restraint Belt (WRB). The use of the WRB is covered in the HOMES manual 2015- section 12 (p135). I can confirm that the handcuff consists of a velcro strap and plastic fitting locking device. The strap that connects the belt to the handcuff can either be pulled into the side of the body, known as secured, or extended out to allow they detainee to eat/drink, known as restricted. The description of how staff sit on the aircraft does reflect how the escort staff are positioned-one either side of the detainee and one sat to the rear. The person at the rear can apply head support from this position. This was introduced during the development stage of the syllabus to avoid head support from the front, which would result in the detainee being bent forward whilst seated. The evaluation from medical advisors recommended head support from the rear only. I have personally observed the seating arrangements during a quality assurance observation on a repatriation flight. The report of bleeding from the wrist post-incident was concerning, redness and soreness can sometimes be experienced but it is unusual to draw blood.

7. D687

Witness statement[100]

UOF – reasonableness and necessity

18.7 I note at paragraph 15 the witness complained of excess force however I am unable to comment further without evidence being presented.

Incident date : 13.05.2018

18.8 I note the injuries reported and the medical examination that took place following this incident. I can confirm that if a detainee reports any injuries following a restraint the F213 should reflect this, even if no obvious signs of injury are observed. The overall quality of F213s varies and in general the healthcare staff only list anything visually seen or reported by the detainee. On most occasions they tend to use terminology like 'no injuries reported'. This is also commonplace within other custodial settings.

[98] [INQ000055]
[99] [INQ000099] Transcript; 3 December 2021
[100] [HOM002446] Witness Statement dated 08.1.2018.

18.9 Paragraph 26 of D687s statement does not reflect what is seen on the footage available. Staff did not storm the room and from the footage the general demeanour was calm, with staff stood relaxed and the door open. It only escalated when DD Houghton entered and removed the ligature. If as described a member of staff sat on his back this would not be compliant with training guidelines and the medical DVD (and training manual) inform staff to avoid this type of restraint due the medical risks it presents, not only from impact injuries but also compromising breathing.

19.0 It is difficult to assess the actual restraint as no staff activated BWVC, and the supervising officer did not carry out the correct planned intervention protocol of having a handheld device to record the incident. If after removing the ligature there was a further risk of self-harm or if D687 resisted staff attempts to remove him from the area the application of reasonable force would be justifiable. The use of handcuffs can, and often do, follow a UOF. They allow greater control and allow physical holds to be removed if compliance is gained. I see no reason why handcuffs could not have been used on this occasion. The small area in which the incident occurred may have been a contributing factor in any impact related injuries. It would take a medical expert to assess the cause of bruising to the ribs.

19.1 If the statement quoted on page 2 was said I agree that this was not consistent with the calm demeanour I observed form the staff stood in and around the room. I hold my view that generally staff appeared relaxed but some of the dialogue would not have been heard on the evidence I was presented with. Language and comments of this type are not acceptable during incidents when a detainee is in crisis. There were managers in attendance along with DCOs, any of them should have advised Mr Connolly of his professional responsibility and in my view any of the DCMs should have removed him from the scene.

19.2 I have reviewed DCM Farrell's account in light of further evidence[101]. The initial use of an inverted wrist hold (known in this circumstance as a back hammer) would be within training and is the approved way for transferring an arm to the rear for handcuffing. Once in handcuffs a decision is made as to whether to remain with the wrist flexed or remove the hand from the wrist and place it on the elbow in order to simply support the detainee and prevent them from falling forwards. If the detainee continues to resist the restraint or compromise the ability of staff to safely move them to the designated relocation area the wrist hold can be maintained. If necessary pressure can be applied through the wrist (PIT) as specified within the UOF Training Manual. This must only be when staff are struggling to gain control and the risk to staff or the detainee requires an additional control measure. Once compliance is gained the pressure is eased off, although the hold can be maintained without pressure being applied. PIT can also include a thumb lock as an alternative to wrist flexion.

[101] [HOM002655] and [BBC000654]

8. D1258

Witness statement[102]

19.3 I am unable to comment on this incident. Anything I could add would merely be assumption of why the member of staff acted this way.

9. D1914

Witness Statement[103]

19.4 I refer to Paragraphs 130-154 of this witness statement.

The language, terminology and unprofessional behaviour contained in paragraphs 133-137 are unacceptable and demonstrate a lack of care for D1914. The description on how to use a shield is incorrect. The type of force mentioned, 'punch him in the chest, leaning knee on his chest, walk over his back' does not reflect training or reasonable or appropriate force. This is even more concerning based on the prior knowledge of D1914 having a heart condition.

My opinion within my first report remains unaltered after considering the additional evidence.

10. D1234

Transcript : - 10 December 2021, pages 43-44 of PDF, 105 – 175 of transcript

P172 para 8 describes the application of a WRB and the leg straps.

I have reviewed the above and have no additional comments to my report of this incident.

[102] [BHM000029] Witness Statement of D2158 dated 13.01.2021.
[103] [DL0000229]

C4. Other Organisations present at Brook House

1. James Wilson (GDWG)

Witness statement[104]

UoF incident - D687 – 13.05.2017 [105]

19.5 I have no further comment to make after reviewing the evidence.

Transcript: 10 December 2021[106]

UOF - Reporting of UOF incidents by GDWG

19.6 I refer to pages 70-71 and 101-103 of this transcript.

19.7 As per my previous comment reporting any complaints or wrongdoing must be reported. I understand the relationship compromise if a detainee where to say ' I don't want to make a complaint' but then goes on to describe an inappropriate action, whether a UOF, verbal language, racism etc the person hearing the comments should report it using confidentiality.

2. Anna Pincus (GDWG)[107]

Witness Statement[108]

UoF incident - D687 – 13.05.2017

19.8 I have no further comment to make after reviewing the evidence.

UoF incidents - Involvement of healthcare

19.9 It is not within my remit or expertise to comment on the performance of healthcare staff or the detainee perception of their role. Healthcare would understand their responsibilities to complete an F213 after every UOF incident. The incident referenced would not comply with their responsibilities and a medical assessment post-incident should have taken place.

20. I refer to paragraph 127 of this statement which discusses force being used inappropriately on detained persons with disabilities. . Within my report I have mentioned training for staff in managing those with complex needs. The UOF to prevent self-harm is lawful and within policy,

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[104] [DPG000003] First Witness Statement of James Wilson on behalf of GDWG dated 15.11.2021.
[105] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 214-242.
[106] tbc
[107] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 214-242.
[108] [DPG000002] Witness Statement of Anna Pincus (Director of Gatwick Detainees Welfare Group-GDWD) dated 10.11.21

however it must be when all other methods have proved unsuccessful or when there is in imminent serious risk of harm.

20.1 I refer to paragraph 203 of this statement where it states that the IMB reported an increase in the use of force and removal from association in 2016. I note that there were staff shortages during this period, which some of the staff statements that I have been provided also highlight. If a correctly operated UOF committee was in place at the time it would have identified the increase in both UOF incidents and the removal under R40. Once senior managers became aware there should have been an action plan to address the trend and an exploration on how to reduce both UOF and R40 removals.

20.2 Paragraph 214 refers to complaints from currently detained persons that disproportionate force is used and is used too readily. My view is that the detainee perception of force could be included within a well operated UOF review committee, including detainee representation. I have recommended (1)[109] that training for incident management is provided to the DCM group.

Transcript: 9 December 2021

D687 - 13.05.2017 UoF incident

20.3 I have reviewed this transcript. The witness did not see the actual incident and was only stating what was told by D687. D687 was handcuffed and was restrained by at least four staff. My opinions in paragraph 238-242 of my report remain as no new evidence is presented.

UoF incident (date?).

20.4 At pages 74-76 of this statement there is reference to another incident however there is little detail of the actual incident so I am unable to comment on the force used. With regards reporting complaints I understand all complaints must be looked into and as with any reporting of wrongdoing staff, regardless of G4S or support groups, must report any concerns.

3 Jamie Macpherson (GDWG)[110]

Witness Statement [111]
Transcript: 8 December 2021[112]

20.5 I refer to paragraphs 59-62 of this statement and the reference to "excessive force". My conclusion in my report at paragraph 187 that handcuffs would have been a suitable alternative to wrist flexion is supported by the detainee admitting he had taken spice. In these circumstances handcuffs provide a greater level of control and remove the necessity to use a technique that a detainee under the influence may not react to in the same way as in normal

[109] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022.
[110] [INQ000111] Mr. Jonathan Collier, HMPPS Expert Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 14 January 2022 paragraphs 187-190.
[111] [INQ000027] First Witness Statement of Jamie Macpherson of GDWG dated 19.05.2021.
[112] [INQ000103] Transcript: 8 December 2021

circumstances. I also feel BWVC footage would have assisted with reviewing the incident. The earlier assault on another detainee was justification for removing to the CSU.

20.6 I have reviewed the transcript evidence and have no comment to make.

C5. Home Office Individuals on site

1. Ian Castle

Witness Statement[113]

UoF generally

20.7 I find it contradictory that paragraph 42 of this witness statement mentions reviewing UOF reports but paragraph 43 states he did not review footage. Surely any good governance and scrutiny would look at both to establish that the force met with all policy and training and that the statements were collaborated by the footage. If only statements were assessed I fail to see how, based on my reviews, that no issues were raised. The overall quality was poor, and many lacked the basic information that is taught during training. See recommendation 7.

2. Michelle Smith

Witness Statement[114]

Home Office of HMIP Recommendations re Use of Force

20.8 I note the updated information at page 18 of this statement on the review process introduced in 2019 by the Home Office relating to HMIP recommendations regarding use of force. I appreciate that the list is a general brief of what is included, but it lacks depth insofar as reviewing the cause of the restraint, and this includes tracking back to the initial conversations and looking at which point the escalation of events could have been addressed. The last point states that the local C&R team facilitated the training for managers. I would prefer this to have come from an external body, such as NTRG. The instructors may have changed since 2017 but the evidence from my documents is that the reviews by local Instructors were not of the standard expected and missed critical information and depth of review.

UoF generally

20.9 With reference to paragraphs 69-71 I can confirm that neither HOMES nor MMPR would be suitable at Brook House. It is interesting that the report states that she was not aware of any reviews or learning during the period. Considering the number of PSU Investigations I would have thought this would alert the Home Office to concerns regarding UOF incidents, even if the claims were unsubstantiated.

[113] [INQ000056] Witness Statement of Ian Castle (DES Area Manager) dated 04.11.2021.
[114] [INQ000057] Witness Statement of Michelle Smith dated 03.11.2021

4. Claire Checksfield

Witness statement[115]

21. I refer to paragraph 45 of this statement which mentions greater use of force at Brook House and other centre. The reason listed as due to the last stay before deportation could account for the higher planned interventions, and possibly the unusually high incidents with naked detainees.

21.1 At paragraph 53 the witness makes reference to the HMIP report, however there is little information for me to comment on regarding the 'partially achieved' marking from HMIP relating to UOF.

21.2 The witness refers to the G4S Action plan at paragraph 56 of her statement. It is reassuring to note the action plan for training, monitoring and investigating UOF. I would benefit from knowing if it within the context of recommendation 3 of my report. I can confirm that the HMPPS policy for the use of BWVC came out during 2017. Brook House did not appear to have any procedures in place at the time and based on my reviews the activation was not consistent across the site. During planned incidents the use was more widespread but during unplanned there was a definite lack of footage available from responding staff.

21.3 I have concluded, based on reading additional statements, that the UOF training manual should have alternate versions for IRCs and any other secure setting other than a Prison. My reasoning is that although the core techniques would remain consistent there is scope for more specific content, such as terminology (cells/room), application of legislations, Detention Centre Rules as opposed to Prison Rules. The unique and often complex requirements of an IRC require a system that reflects the working environment and the purpose of a centre.

5. Alan Gibson

Witness Statement [116]

PSU investigations

21.4 I have reviewed the PSU Investigation and the unsubstantiated finding into the complaint made by D687 of excessive force. Paragraphs 6.1.20-6.1.29 show a number of inconsistencies with the footage that I observed. Paragraph 6.4.8 of the account of DD Haughton was that his intention was to remove the ligature only and not to use force. The resistance by D687 was the reason for force along with facilitating the removal order. Paragraph 7.5.23 details the G4S cut-down procedure. I would question why any of the staff on scene did not follow this procedure initially and why DD Haughton resorted to offering a light for a cigarette to carry out the action. Paragraph 7.5.35 identified the lack of BWVC protocols in place at the time. The new operator, Serco, have addressed this matter and BWVC procedures have now changed.

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[115] [HOM0331981] Witness Statement of Clare Checksfield (Head of Detention and Escorting Services at the Home Office) dated 29 October 2021

[116] [HOM0331980] Witness Statement of Alan Gibson Head of Operations dated 01.11.2021

21.5 I note reference to the HMIP report at paragraph 48 of this statement and confirm I have no further comments to make from the additional information.

UOF oversight

21.6 I agree that any post-incident review includes looking at the root cause of the act of indiscipline, and more importantly how to avoid repeated situations. This is a lessons learnt culture which addresses how staff can play a major part in a preventive initiative scheme. A better understanding of the removal scheme would also benefit managers, however I hold my view that Home Office staff are best placed to inform detainees of removal orders.

6. Simon Murrell

Witness statement[117]

Changes post Panorama

21.7 At paragraph 44 of his statement Mr Murrell speaks of changes affecting UoF post Panorama. I particularly like the addition introduced post Panorama of a detainee welfare needs assessment on arrival. This gives staff an opportunity to understand any specific needs of the individual and adapt their support in line with guidance.

21.8 Having more staff will always be beneficial, provided they are correctly trained and understand their role and responsibilities as Custody officers, and I also welcome the mentor scheme, provided the mentors are assessed prior to being allocated to new staff.

C6. Other Transcript Evidence

1. Sile Reynolds

Transcript: 8 December 2021[118]

21.9 I have been provided with and have reviewed this transcript and have no comment to make on the same.

2. Dominic Aitken

Transcript: 8 December 2021[119]

22. I make the following observations from my review of this transcript:

22.1 Use of force

The incident referred to on page 75 paragraph 11 appears to have been initiated by another detainee. Mr Aitken did not appear concerned at the force used by the member of staff who

[117] [HOM0332006] Witness Statement of Simon Murrell dated 24.11.2021.
[118] [INQ000103]Transcript: 8 December 2021
[119]]INQ000103]Transcript: 8 December 2021

responded. At page 76, paragraph 16 the witness mentions the Incentives and Earned Privilege (IEP) scheme used in Prisons.

22.2. I am not an expert in this system and can only add that any consideration of the scheme would require a legal perspective of what detainees are allowed and what could be removed, for instance in Prisons the TV can be removed from those on basic regime. I am unsure if this would this be permissible or lawful in an IRC.

22.3 Prioritisation by staff of dealing with disruptive behaviour

Whenever a general alarm is activated staff identified to respond and those who are in a position to respond must do so. Any situation must be assessed, sometimes referred to as a dynamic risk assessment, by the orderly officer (or equivalent), also known as Oscar 1. This is normally at DCM grade and if more than one incident takes place other DCMs grades would be expected to respond to the second incident.

22.4 Allocating of resources and prioritising incidents must always be based on the risk factor. Any situation where there is a risk to life, or serious harm must take priority, and if staffing levels restrict managing all ongoing incidents a best-efforts approach to the lesser risk incidents would take place.

22.5 Preserving life is the highest priority and managing situations of this nature (multiple incidents) should form part of the DCM training package within my recommendation 1.

3. Anton Bole

Transcript: 8 December 2021[120]

22.6 I have been provided with and have reviewed this transcript and have no comment to make on the same.

C7. Further documents

22.7 I have reviewed the following document and provide my comments below.

1. Expert Report of Dr Hard dated 18.11.2021 (Expert to the Inquiry) [121]

Inadequacy of UoF training

22.8 The report states the conclusion that training was inadequate in the UOF but does not explain in which areas.

UoF Incident - D1527 - 25.04.2017

[120] [INQ000103] Transcript: 8 December 2021
[121] [INQ000075] Report of Dr Hard dated 18.11.2021

22.9 On page 58 Dr Hard mentions Nurses trained and refreshed in UOF. Within my experience it is unusual for any healthcare staff to be trained and refreshed in anything other than personal safety training.

23. Within my experience it is also unlikely and not appropriate for a nurse (or other healthcare staff) to assess what techniques are being applied in the context of if they are approved techniques. I would also question the nurse having authority to instruct staff to remove or modify a technique not within the training syllabus. Whilst staff are expected to only use approved techniques it does not necessarily mean other techniques, used in exceptional circumstances and only used as a last resort and which are necessary, reasonable and proportionate, cannot be used. I accept, and policy dictates, that if a nurse observes a particular technique or action that is causing harm to the detainee, they can instruct staff to either release of modify the technique, this applies regardless of whether the technique is approved or not. Staff are ultimately responsible for their actions and must record and evidence why they used techniques not prescribed in training.

23.1 The next case study is in regard to a UOF on D1527. I agree with the opinion of Dr Hard and that a nurse in attendance should have identified the actions of Mr Paschali to be inappropriate and putting D1527 in danger. Dr Hard is correct in stating that any healthcare staff involved in the observation of a UOF incident must record their observations on the F213. If any inappropriate actions took place the nurse, as with all staff, must report wrongdoing through the appropriate channels.

<u>UOF Incident - D687 - 13.05.2017</u>

23.2 The comments are not within my remit, in particular the level of medical support at Brook House. I have no comment to make.

<u>UoF incident - D1914 - 27.05.2017</u>

23.3 I have no further comment after reviewing the report by Dr Hard. My findings and opinion of this incident remain and I feel the medical history referred to within Dr Hard's report justify my non-medical assessment that force was not necessary or indeed suitable for the reasons listed by staff on the UOF documents.

<u>Conclusions to report</u>

23.4 I agree, and it is good practice, to invite healthcare staff to UOF training, and most Importantly the scenario-based training section, so they can see, i) the techniques being applied, ii) understand their role and how they work alongside the UOF supervisor, iii) Identify those techniques which cause the greatest concern and the taught methods for responding to a medical emergency.

Work is ongoing for additional guidance and information for staff on a range of mental health conditions, such as autism. This will be included within a revised UOF Policy Framework and covered during initial and refresher training for staff.

2. Brook House Inquiry - Supplementary Report of Dr James Hard dated 26.01.2022[122]

23.5 I have reviewed Dr Hard's additional findings and provide my views:

UoF Incident - D1527 25.04.2017

23.7 I re-iterate that healthcare staff have a role during any UOF to observe and monitor the condition of the detainee. I am unable to assess whether the nurse in question was in a position to see the technique being used on D1527. If she did witness anything of concern she should have instructed staff to remove the technique or modify it so that it no longer posed a risk to D1527.

UoF Incident - D687 - 13.05.2017

23.8 I am now aware that D1527 was on an open ACDT and self-harm was a known risk factor. The force used during the incident was necessary, reasonable and proportionate, the only other area which may have been better explained in the UOF reports was the communication with D1527 when considering him being vulnerable and on an ACDT.

Interplay between Rule 35 and Use of force.

23.9 During planned incidents the healthcare staff must pass on any information related to the detainees medical or mental health condition. This should be factored in by the supervisor of the incident, but at present very little additional material is available for managing UOF incidents involving detainees with mental health conditions. There is a limited section on managing detainees with health conditions, but this does require a review and enhancement of specialist knowledge.

Training

24. I support a training system that interacts across medical, welfare and UOF. I note Dr hard highlighted the potential increase in training to achieve this objective. However, I do believe there should be a consideration to improve all aspects of the UOF, and this model would be a step forward and promote a more considered approach to planned interventions.

24.1 Conclusions

24.2 I can confirm that I have not seen any medical documents within my review of the UOF incidents at Brook house during the period in question.

24.3 I do not know if staff had any knowledge or known the extent of the individuals vulnerabilities. Where there should be a change in my opinion is the time and effort to engage and communicate that reflects those vulnerabilities. I am not sure, at the time, staff possessed these skills and did not consider using an alternate, personalised approach to issuing Instructions. I accept that the incidents when a detainee is, or has, self-harmed does raise the question of 'did staff use all reasonable attempts to resolve and was force the last resort'.

24.4 In particular my opinion on incident 120/17 involving D687 is enhanced when considering the conclusions of Dr Hard. I still hold the view that the incident involving D1914 did not meet, in

[122][INQ000112]

my opinion based on the evidence I have, the general principles for using force. What has to be appreciated that in some instances force is the last and only remaining course of action. These instances would include serious acts of self -harm. My opinion on the incident involving D1527 would fall under this category.

24.5 I have recommended (2) that a newly designed communication package should be incorporated alongside the physical techniques training. This must cover all aspects of mental health and dealing with vulnerable individuals.

24.6 I do believe that certain medical conditions and disabilities result in a difference in the techniques used. For instance, if a detainee has a recent wrist injury that resulted in surgery, I would not expect staff to apply a PIT to that wrist. This information and knowledge can be cascaded during the briefing before a planned intervention. Where it is not so easy is during unplanned UOF incidents involving staff who do not regularly work in the area and who are responding to a general alarm.

24.7 There is information coming through now on bespoke strategies for managing those with mental health issues. With an increase in staff within the centre there is more scope for individual personal officers. Their role will be to document how to engage with the detainee, understanding triggers for behaviour and tried and tested de-escalation methods.

24.8 I strongly support individual crisis management plans , however my previous example can still occur and it has to be appreciated that a best efforts approach has been devised but the complexities within a custodial setting can at times make them difficult to apply operationally.

<u>UoF incidents 134/17 (D1914) and 86/17 (D2159)</u>

24.9 At paragraph 665 I comment that that these should have been "managed as a medical removal rather than a disciplinary move".

25. To clarify, my term disciplinary move refers to a planned UOF with staff in full PPE, including a shield. My opinion is that both incidents did not warrant this. I also hold the opinion that the reaction of both detainees substantiates this. If when opening the room door the supervising officer paused and observed D1914 and D2159 I would expect them to draw the same conclusion as I have.

25.1 A medical removal would be in the instance of D2159, the room was unhygienic and would not be suitable for staff to enter without some form of protective clothing. Due to the conditions staff should have been given protective overalls, face masks, gloves etc but not UOF PPE. There was no need for full PPE for a person who had been on food refusal for several days and was almost bed ridden. This concerns me in regards to the DCM basing every situation on its own merits. They appear to default to full PPE whenever a detainee is refusing to move. The PSO states PPE is advised, it does not mandate it and an individual risk assessment should be carried out before deploying staff.

3. Report of Prof Bosworth dated 17 November 2021 (Expert to the Inquiry)[123]

25.2 I make the following observations from this report:

Staff attitudes towards women conducting use of force incidents

25.3 I refer to paragraph 7.6 of the report. I can confirm that the evidence I reviewed did not include many female staff. Most of the planned incidents were carried out by male staff. If a fully functioning UOF committee was in place I would hope this would have been identified. If records of staff UOF involvement, based on submitted UOF reports, had been collated this would have also identified the lack of female involvement. Female staff receive the same training and are assessed on the same criteria as male colleagues.

2.5.4 Whenever selecting staff, if that is indeed an option and not just who is on duty, then a mixture of experienced and inexperienced staff should be a consideration. The risk of using the same staff is psychological burnout, increased stress, over reliance on a small number of individuals, and importantly a detainee perception of 'suitable crew' for any planned removals. * The term suitable crew was unknown to me previously but I have read it several times during my reviews.

25.5 I can draw on my own experience of females within a custodial setting. In the early 1990s I worked in the Segregation Unit of a YOI, often with a solitary female colleague. In my view this presented an effective mix of skills and personalities, which are essential in any custodial setting. I have served on the national team with female colleagues who have carried out the same role as myself, again we have different skills that complement each other.

25.6 Comments on officers discussing use of force and using racist, sexist and homophobic language, as well as lots of swearing.

25.7 I refer to paragraph 7.7 of this report. I have commented on the attitudes and conversations during the incident involving D275 in paras 265-267 of my first report. Some of the descriptions amount to bravado and paint an incorrect picture of the behaviours and attitudes expected of staff. I find it disturbing that a local UOF Instructor behaves in this way and that he ignores his responsibility to promote professionalism and the correct approach to dealing with serious incidents. He was a role model for younger inexperienced staff and should have understood how he can influence attitudes and behaviours.

25.8 My experience within HMPPS, and working with other agencies, is that swearing is part of normal vocabulary. I hear staff, managers (senior and junior) as well as detainees/prisoners using swear words, cursing etc in everyday conversation. The context that using such language when engaging with a detainee is important to consider. When trying to resolve a problem or calm a detainee who has received bad news for instance, using swear words can inflame the situation. Training in calming, rapport building and persuasion are key components of a resolution strategy, with a selective choice of suitable language being used.

25.9. I refer to paragraph 10.15 of this report. I am not familiar with the contractual role of the IMB at Brook House. If the agreed DSO was not completed it would clearly breach the correct

[123] [INQ000064] Report of Professor Bosworth dated 17.11.2021

protocol. Instances where UOF reports were not submitted have been identified in paras 34 viii, 35 and 42 of my first report.

26. HMIP's concerns

26.1 I refer to paragraph 10.21 of this report. During some incidents I would agree that the briefings before an intervention were very good. But there were occasions when they did not meet the same standard, therefore I disagree with a generic comment of very good. The attempts at de-escalation also varied, some good and some poor. I accept that the HMIP report was generic and did not review all incidents to the degree I have during this inquiry. The increase in UOF could have been attributed to a change in the population, or the failure to have adequate staffing numbers. These are just two possibilities that I have read from witness statements.

26.2 Conclusions

I agree with paragraph 11.2 and 11.3. Inexperienced staff, a changing detainee population and the presence of drugs, especially spice, caused a number of changes within the centre. It is also evident from the footage that staff demonstrated unacceptable attitudes and behaviours. With staff retention being a constant issue it is difficult to embed the culture aspired to. This is particularly challenging when experienced staff influence younger staff with negative beliefs and attitudes toward the detainee group.

26.3 I endorse paragraph 11.5 in full. This would be the only way to bring about a change culture, and inclusion of detainee representative groups brings a shared approach that promotes inclusion in decisions made and builds respect, confidence and transparency between staff and detainees.

I considered Prof Bosworth's conclusions on staff culture, in particular on racist, threatening and abusive language.

26.4 When reviewing the incidents it was only during the incident involving D275 that any inappropriate comments were made. Some of the footage from Mr Tulley picked up similar behaviours and attitudes from staff when in offices. If any evidence of racist attitudes had become apparent during any of the incidents that I reviewed I would have made reference to it within my findings. At no time did any of the dialogue from the incidents give cause for concern, although I accept that on many of the incidents there was no audio evidence.

26.5 The incident involving D1527 (105/17) was a clear example where disrespectful comments were made, which I addressed in paragraphs 37, 41 and 51 within my first report. I would have addressed such behaviour within my findings due to one of the key components of any incident is the language used by staff and treating the detainee with respect. Staff must demonstrate compliance with professional standards during any interaction with detainees and treat them with respect and dignity.

26.6 Due to only observing UOF Incidents and having no personal experience of the Centre during this period I am unable to provide any comments on whether a racist culture existed or not. The staff making inappropriate comments during my observations account for a small percentage of the staff employed at the time. I have made reference to the apparent failings in reporting wrongdoing, but I have no evidence to say whether this was racially motivated or not.

26.7 I found no evidence of racism being the motivation for any of the UOF incidents I observed. It must be taken into account I only observed the events form briefing and intervention, or staff responding to an unplanned incident. This would not be sufficient to make any conclusions.

26.8 In the Sussex Police report[124] I refer to the 'conflict cycle' or Betari's box method being used in respect of the UoF training on communication skills and states that "this shows how attitude and behaviour are linked, and importantly how any negative attitude to a situation may influence the actions taken". It is several years since I delivered or observed training in this model. There was never any specific description of the motivation for the negative behaviours or attitudes, whether racism, homophobia, antisemitism, or any other form of prejudice. It focussed on developing better attitudes and behaviours toward the opposite person in order to develop mutual respect and to influence their responses.

26.9 I have trained UOF for over 26 years and I am an accredited weightlifting instructor and martial arts coach. My reason for mentioning this is that as an Instructor/coach you develop an ability to identify poor practice in technical aspects of the specific activity, whether it be completing a lift, mastering a specific kick, or when observing UOF techniques. The incorrect application of handcuffs in incident 135/17, involving D149 was a clear example of incompetence in applying handcuffs. The result was that the carry technique could not be performed correctly, and that the application of pain could not be controlled. The DCM tried to re-adjust which demonstrates to me that he recognised the problem but was unable to rectify it. Paragraph 59-61 address this matter. I also note two of the staff had only 5 months service at the time. They may well have never experienced an incident of this level previously and lacked the operational skills to deal with such a difficult removal.

27. Paragraph 67 covers the relocation where my knowledge and experience led me to comment on the misapplication of a leg control technique. It is clear to a trained eye that the member of staff trying to apply the hold was incompetent and even started in the wrong position when there was sufficient space to work in. The DCM did try and coach the member of staff through the technique, but having to do this during a live incident, especially when the detainee is in the prone position, must be avoided. This should have been identified in the local incident review and additional training recommended for staff who struggled during the incident.

4. Panorama Investigation - Hearing Summary - list of 12 DCOs dated 6/07/2017[125]

Dismissal of John Connolly for unprofessional misconduct.

27.1 All of the reasons listed were evident during the footage involving D275, notably paras 2 & 3 which relate to his role as a UOF Instructor and the influence he has coupled with the expectation of being a role model and promoter of professional good practice in line with policy and organisational standards.

5. Role of the Security and Use of Force team with regard to Brook House in 2017.[126]

[124][SXP000133] para. 8
[125] [HOM001895] Panorama Investigation Hearing Summary List of 12 DCPs dated 6.7.2017.
[126][HOM0331998] Role of the Security and Use of Force team with regard to Brook House in 2017

27.2 Paragraph 74 outlines the changes made to the management and oversight of UOF. I welcome the change but would recommend the centre operator adopts the Good Governance Toolkit (GGT) developed by HMPPS. This was not available in 2017 but is now working across the custodial estate. I would also recommend that external attendance for reviews of force would add a level of transparency and openness to the process, and as with my recommendation 3 involve representatives from the detainee group when appropriate.

6. G4S Gatwick IRCs "Use of Force" Control and Restraint policy, issued March 2016.[127]

27.3 The document is mainly derived from PSO 1600/PSI 30/2015, DCRs and the UOF Training manual. None of the information would result in any of my findings from the review to be reconsidered or changed.

7. Integrity, Professional Standards and Prevention: Learning the Lessons from Brook House. [128]

Reporting and governance

27.4 As per my response to the question above. I do not think this is sufficient and that GGT along with my recommendation should be added to the changes listed. It is interesting the review of staff who have 3 or more complaints. In my view a review should take place after one complaint, and each further complaint as they are received. I am not sure why staff would need to have reviewed after 3 UOF incidents within a 3 month period. If appropriate governance is in place the individual reviews would identify any issues. Within my experience staff who have involvement in 3 UOF incidents during a 3 month period would not be excessive or cause concern, provided reviews have taken place.

Expand use of force analysis and assurance.

27.5 The model looks complex on paper and is probably simpler when described. I welcome the increase in Home Office scrutiny and any means to improve overall governance.

To review assess and analyse use of force within detention and escorting

27.6 My recommendation is for external scrutiny of the current processes to fully understand the mechanisms in place and how incidents are reviewed, addressed and the follow-up procedures for any examples of behaviours and actions that are inappropriate.

The independent investigation is asked to examine whether the use of force on detainees is subject to appropriate and adequate reporting, governance, assurance and improvement arrangements.

27.7 The findings would be interesting to assess against my findings and recommendations. I would further recommend that a joint approach between the DES Head of Security and HMPPS would benefit the overall process and provide consistencies between custodial sites.

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[127] [CJS000360] G4S Gatwick IRCs "Use of Force" Control and Restraint policy , issued March 2016.
[128] [HOM0331995] Integrity, Professional Standards and Prevention: Learning the Lessons from Brook House, undated.

8. Project: Brook House Action Plan – G4S Project Highlight Report dated 13/10/2017[129]

27.8 A weekly review of use of force in the form of a force review committee is a step forward but there must also be a provision for immediate action in the event of; i) a complaint made regarding the restraint, ii) any injury to a detainee or staff, iii) any evidence of inappropriate behaviour, verbal or physical. The make-up and experience of the review committee must be carefully considered. I promote the inclusion of independent members who can give a lay-person perspective.

9. Serco Gatwick IRC/PDA - Use of Force, RFA & TC Standard Operating Procedure.[130]

27.9 It is a positive step that all staff are now issued BWVC and guidance is provided to activate when responding to or using UOF. One factor is to remind staff that if a detainee becomes challenging the terminology should be positive rather than threatening, for instance explain why evidence is being gathered and that it reassures the detainee that staff will also be recorded, which can be used in any following complaint or investigation. This guidance does not cover the use of BWVC by escort staff that I recommended.

28. I note the instructions on page 8 that handheld devices are used for planned interventions – recording also covers any attempts at negotiation – medical assessments are captured on the recording.

28.1 These are all positive improvements in evidence collation and MUST be used during any UOF incident review process.

28.2 My recommendation 8 would address the retention of BWVC footage. It does not mention how long footage is automatically saved before being deleted. In my opinion footage must be retained for at least 120 days because use of force review are held quarterly. The importance of the auto-save is if an incident that was not a concern at the time is reported a few weeks later the footage would still be available.

Use of Force review

28.3 It appears the first review is an operational level focussed review. Being within 24hrs of the incident it is unlikely any external stakeholders or interested parties would attend.

28.4 Any lessons learnt must be incorporated into training and if necessary staff newsletters/notices sent out to advise on good practice and areas of concern.

28.5 Personally I would place responsibility for the UOF on the Director, and they should in my opinion chair the UOF committee. In their absence the Deputy Centre Director should take over. My reasons are the multi-agency approach would provide a direct line for any concerns to the Director and avoid the bureaucracy of going through various layers of management.

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[129] [CJS0073903 Project: Brook House Action Plan – G4S Project Highlight Report dated 13.10.2017.
[130] [SER000068] Serco Gatwick IRC/PDA - Use of Force, RFA & TC Standard Operating Procedure, issued 27/04/2020

10. Serco PCO ITC Schedule of Learning Timetable- Weeks 1-8, undated [131]

28.6 In considering whether the use of force training in the ITC is sufficient I am concerned that the UOF training includes batons. To the best of my knowledge Batons are not authorised or carried within an IRC operated by a private provider.

28.7 UOF is on week 3 along with BWVC. I feel UOF training would be better placed after conflict management training, which is on week 7, day 2. This would give students the rightful assertion that UOF is only used as a last resort and when all attempts at conflict management have been tried and been unsuccessful. The use of conflict management skills should be incorporated into UOF scenario training to educate staff that the two are used together, and that even when force is used initially good conflict management skills can de-escalate the situation resulting in force being removed completely.

11. Training Syllabus DCO Gatwick estate [132]

28.8 When determining whether the Use of force training is sufficient in the ITC, my initial impressions are that the conflict management sessions on week 6 (Monday) should be brought forward to before UOF training. This would allow the skills developed through the conflict management training to work alongside UOF, and to further emphasise that they should be used before using force, which is the last resort when all other methods have been unsuccessful.

28.9 Without resorting to any assumptions I do question why UOF is at week 2? There may be a reasonable explanation but I am of the opinion core skills should be taught first and then UOF training. By training core skills of a DCO first the tutors can evaluate the suitability of candidates for the role earlier and address any concerns before moving to UOF training.

29. Note * I am now of the opinion that the manual should reflect the actual agency, alternate versions for IRCs that quote DCRs and legislation are more applicable. Likewise guidance for the completion of UOF reports should be reflected- 72 hours for HMPPS compared to 24 hours for IRCs.

29.1 Further Note* The personal safety section has been replaced with a new system known as SPEAR. The C&R section also includes the use of Rigid Bar Handcuffs (RBH) which have been added to the authorised equipment for HMPPS staff. Additional training has been allocated by HMPPS, although this will also include PAVA training which is not applicable to IRCs.

12. Serco The Role of a Detention Custody Officer (revised for IRC) Presentation.[133]

29.2 I only have a limited knowledge of this part within the initial officer training programmes across various agencies. I would have expected something on managing UOF and complying with decency and respect at times, however this may be covered elsewhere on the course.

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[131] [SER000170] Serco PCO ITC Schedule of Learning Timetable- Weeks 1-8, undated
[132] [SER000256] Training Syllabus DCO Gatwick estate
[133] [SER000412] Serco The Role of a Detention Custody Officer (revised for IRC) Presentation, dated 1.1.2018.

13. Use of force Powerpoint for Serco training[134]

29.3 These slides are derived from a larger powerpoint presentation that includes communication, medical and report writing. They are the current version but a review is under way with changes expected around May 2022.

14. HM Prison & Probation Service - Personal Safety SPEAR presentation, undated[135]

29.4. These are the current slides for SPEAR personal safety training which is delivered to all operational grades and to civilian staff, agency workers and official visitors at the centre.

15. Use of force report writing guidelines 2019.doc [136]

29.5 My first observation is the reference to Prisoner and not Detainee, which should be changed to reflect an IRC. Most of the content is a direct lift from the UOF report writing powerpoint issued to all Instructors. Page 6 lists what is known as the UOF continuum. My concern is that the continuum includes a wide range of behaviours, starting at compliant and verbal resistance/gestures. It must be emphasised to staff that force is not lawful for these reasons alone and would not meet the general principles.

29.6 In recommendation 7 of my first report I include sample testing of reports in addition to them being reviewed during UOF reviews. If an effective review process is in place it would identify poor quality of reports and have a structured approach to improving individuals understanding and ability on how to complete the report to a professional standard.

29.7 Providing staff handouts and posters in central offices would help staff to remember how to complete a report. The introduction of interactive training would also be a worthwhile consideration.

16. Spreadsheet - Use Of Force stats Spontaneous and Planned 2020.[137]

29.8 The spreadsheet confirms that unplanned incidents are still much higher than planned. Based on my previous reviews it could still be possible that staff misinterpret the definition and actual application of the two types of incidents.

29.9 The huge spike in unplanned incidents in June 2021 should have resulted in a management inquiry as to the reasons. The drop in UOF Incidents between December 2020- January 2021 is noticeable.

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[134] [SER000417] Use of force Powerpoint for Serco training
[135] [SER000419] HM Prison & Probation Service - Personal Safety SPEAR presentation, undated
[136] [SER000421] Use of force report writing guidelines 2019
[137] [SER000430] Spreadsheet - Use Of Force stats Spontaneous and Planned 2020 & 2021 (June 2020 to Oct 2021

30. Overall these figures are not representative of Brook House at the time of the investigation. This is due to the reduced operational capacity at the time and the additional staff in post following the handing over of the operating contract to Serco.

30.1 Additional information

I attended Brook House in early 2022 and met with the new centre Director and Deputy Director. I was given a tour of the site and was informed that a major refurbishment and redecorating programme was in progress. At the time the number of detainees held in the centre was considerably less than the period of the Panorama investigation (around 100 compared to 400). Staffing levels has also increased significantly and was almost double the previous number (up to approx. 400). I was informed that BWVC are now issued to all staff and that the training figures for UOF were approx. 90%.

These are all positive changes and reflect the efforts of the new provider, Serco, to improve all aspects in the operation of the centre.

17. Dr Brodie Paterson[138]

30.2 Dr Paterson writes essentially about an alternative use of force model in mental health context (which seem to incorporate mainly de-escalation techniques). Dr Paterson at para. 140 states that this "therapeutic model" is now being trialled in prisons. I am not aware of any establishments within the Prison Service of England and Wales trialling this model. In terms of this being a model appropriate for use at Brook House I do not profess to being an expert in therapeutic care and have little background knowledge of specialist working with those with mental health conditions, PTSD or other vulnerabilities.

30.3 There are a number of experts who advocate a more therapeutic approach, which I whole heartedly agree with, however there must also be a contingency for the use of physical force when all other methods have been unsuccessful, or when the urgency of the situation dictates that staff must use force to preserve life or prevent serious harm. The UOF Training syllabus is often criticised for its lack of content on the specific issues of care, preventive measures, rehabilitative skills, and dealing with mental health or other vulnerabilities. I must state that the manual is specifically aimed at the contingency end of care and is in no way designed to cover all the specialist areas listed above and any other training in managing behaviours to be cascaded through the practical elements. The ideal model is to incorporate a combination package of both models, one being delivered by trained staff prior to UOF training and the second by accredited UOF Instructors who have a knowledge base in the care methods and who can align them with UOF training. Many of the de-escalation and communication skills would be transferable into UOF incidents and scenario-based training would condense the two as part of the DCO accreditation process overseen by representatives from both groups.

30.4 Dr Paterson makes some valid points in paras 143-145. It must be a consideration that Brook House, and other IRCs, do not hold only those with mental health issues or who are vulnerable. There is a proportion of the detainees who have no underlying issues and who may have

[138] TBC

previously served time in prison. This provides a complex mix of detainees, who have a wide range of care needs and who mat react differently to the circumstances they find themselves in. More specific to IRCs is the number of people held who have experienced torture, loss of close family members and persecution in their home country. This can result in more specialised care methods and should be provided by external services.

30.5. I am of the opinion that a bespoke package working alongside current UOF training to be the best option for improving both the culture and care at Brook House. A good example is the MMPR training package which has a section developed by a behaviour management expert alongside the physical techniques developed by HMPPS. MMPR national trainers and local coordinators deliver the full syllabus, which may not be suitable for IRCs, where a dual tutor lead delivery may be more appropriate.

30.6 HMPPS have introduced a similar version of this model. Training in Five Minute Intervention (FMI) is being rolled out across the estate to supplement UOF and behavioural management. I have previously seen a similar model used at Woodlands Juvenile Justice Centre N. Ireland, where they introduced Therapeutic Crisis Intervention (TCI) to work alongside Physical Control in Care (PCC), which was the predecessor of MMPR. Refer to recommendations 2 and 6 from my first report.

30.7 Note-Mr Paterson used the 2006 UOF Training manual for his review. This version was replaced in 2016 by version 2015 v2.1. In answer to the test criteria for techniques, para 33, Dr Maconochie carried out his medical evaluations using a risk matrix method. All techniques were assessed whilst considering age, gender, physical abilities, risk of injury and the necessity to use force when other methods have not been successful.

18. First witness statement of Professor Katona[139]

30.8 I have reviewed the relevant provisions of this report. It is not within my remit or experience to comment on the holding of detained persons with mental health in an IRC where their conditions cannot be managed.

30.9 Some of the terminology used in Annex 1 para 27 exemplifies my concerns over report writing by staff. If as recommendation 7 states random checks are made this type of language and the picture it paints would be identified, and corrective training provided to the report author.

C8. Corporate statements

1. Home Office - Philip Riley [140]

31. <u>Use of force improvements.</u>

This is referred to at paragraph 39-41 of the witness statement. His viewpoint is that the incidents televised on the Panorama documentary did not reflect the general UOF at the time is completely understandable. The relatively small number of incidents recorded over the period cannot be used to benchmark all incidents. However, the attitudes, behaviours and

[139] [BHM000030] First witness statement of Professor Katona
[140] [HOM0332005] Witness Statement of Philip Riley dated 12.11.2021.

actions of some do cast doubt on other UOF during the investigation period which were not captured on the footage.

31.1 The information about the population within Brook House at the time makes interesting reading. As with any custodial setting a change in the population can have negative results and it is worth noting the comment including a higher proportion of TSFNO, some of whom presented a higher risk to staff, other detainees and themselves. The witness also states that there was a the perception that staff/detainee relationships had not worsened.

BWVC

31.2. The increased use of BWVC and the increased scrutiny, by way of a dedicated group, is a massive step forward in monitoring force and developing better strategies for preventive mechanisms within the centre. It would be worthwhile measuring current practice against the recommendations (3) set out in my report.

31.3 The wider use of BWC is referred to at paragraphs 70-71 of this statement. I am pleased that a formal process for investigating why BWVC activation did not take place has been introduced. It is unacceptable for individuals to fail to activate when attending or being involved in incidents where challenging behaviour is presented. The introduction of DSO 04/2017 would be worth measuring against my recommendation (5), and I would be keen to know if the escort provider is also working to this policy.

2. G4S- First witness statement of Philp Dove, Managing Director of G4S Health[141]

UoF and healthcare

31.4 A. The description of training for healthcare staff is correct and as defined in PSI 30/2015. Healthcare staff should in my opinion form part of the UOF review committee in order to add a medical opinion on the techniques used and the potential risk to detainees being restrained.

31.5 Healthcare staff should attend all incident debriefs and it is concerning that they did not on all occasions. All staff involved in the incident should be invited to the debrief and have their opportunity to make any comments or raise any concerns. It is good practice for healthcare to be consulted within the decision-making process for relocating a detainee to the CSU. They can provide any medical considerations on why the CSU may not be appropriate, or to give any advice on the specific requirements for the detainee.

31.6 The failure to complete an F213 after every UOF is area that should have been identified within the 24 hours review. It was on the check list completed by DCM Webb and is a mandatory requirement for completion. If force was used but not recorded (despite this not being policy compliant) healthcare should have recorded any examination on the detainee.

[141] [CJS0074040]

3. G4S – First witness statement of Gordon Brockington.[142]

31.7 I have reviewed the relevant provisions of this witness statement.

During my review of the incidents during the period of investigation I identified that senior managers did not generally appear within the footage recorded during incidents. My expectation is for the Duty Director to attend any planned incident and respond to any unplanned incidents. This did not happen on a regular basis, and it could lead to inexperienced DCMs taking the lead in areas where they lacked the necessary knowledge and skills to effectively manage.

31.8 I have not found any documented evidence to support the claim that guidance was provided to staff following any UOF reviews (paras 50 & 51). Refresher may have addressed some of the issues identified but it is not a requirement to record the content of refresher training in such detail.

31.9 It is correct that staff whose UOF accreditation had lapsed could not take part in planned incidents.

32. MMPR training is for the under 18 estate and would not be a requirement at Brook House.

32.1 None of the incident documents completed by the Duty Manager (DCM) that I reviewed mentioned consulting with the Duty Director before authorising force to be used. I have not seen any minutes from the UOF committee meetings mentioned in Mr Brockington's report.

32.2 With regard to para 176 I can compare the situation of a 'no notice charter' to my experience of removing prisoners from an establishment without prior notice. Whenever you enter and inform a person they are moving straight away it can be badly received and cause a level of non-compliance. This may be due to the suddenness and the possible fear and apprehension experienced by the person. Given that this was a regular occurrence it should have been something that was discussed and an action plan developed for managing incidents of this nature that was then cascaded to the DCM group.

32.3 Debriefs of any detainee (still at the Centre) should have been carried out post-incident in line with PSI 30/2015.

D. Responses to Further Supplementary questions

I have been asked to respond to specific questions from Detained Persons who are Core Participants which have been provided in four annexes: D1527, D1914, D1538 and D149. My responses are below.

Annex 1 – Incidents relating to D1527

Additional Documents Required

[142] [CJS0074041]

Accounts by detained persons themselves are important for Mr Collier to understand the use of force from the perspective of the victims; their version of events, the impact on their physical and mental health, and a historic context of their vulnerabilities that the officers involved ought to have been aware of.

For D1527 – and specifically with incident 114/17 on 4 May 2017 in mind- we request that Mr Collier is provided with the following documents:

1. D1527's Rule 9 Witness Statement dated 19 November 2021 (DL0000144). D1527 sets out his account of the events of 4 May 2017 from paragraphs 68 to 79 (DL0000144_0025 - _0029);

2. D1527's Written Response to the Rule 9 Request (provided by Duncan Lewis but not yet disclosed by the Inquiry to other CPs);

3. The psychiatric report of Dr Amlan Basu dated 27 December 2017 (CPS000011). References to the events of 4 May 2017 are made at paragraphs 12.1.27, 12.2.7 and 16.2.1 but Mr Collier should familiarise himself with the report in full to understand the extent of D1527's known psychiatric state at the time officers used force on him;

4. The psychiatric report of Dr Thomas dated 31 May 2017 (HOM002997)

5. The Rule 40 decision to remove D1527 from association (HOM000251);

6. Transcript and Video Clip of KENCOV1012 - V201705040022 clip 2 (BBC000664 and TRN0000005)1 and KENCOV1012 - V201705040021 (BBC000670);

7. D1527's healthcare records (CJS005997 - specific entries are referenced below)

UOF incident Log 114/17 — D1527
"Detainee concerned: D1527
Date of Incident: 4th May 2017

Reason for force as listed on the UOF report: Non-compliance, prevent self-harm, prevent injury to third party, prevent injury to oneself
Staff involved: DCM Dix, DCOs Bromley, Shauket & Yates"

In relation to this use of force, the accounts given by the guards are inconsistent and D1527's account also differs. There is a primary issue of determining factually what happened which impacts on the assessment of the use of force. In those circumstances, we would suggest that Mr Collier's assessment may wish to take into account the possibility that his presumption as to the factual scenarios (based on taking certain accounts at face value) may not be sustained.

<u>Background: D1527's Mental Health</u>

We would ask that Mr Collier re-appraise this incident on the 4th May in light of D1527's serious mental health issues at the time. According to a contemporaneous assessment by Dr Thomas of D1527's mental health, he was, in May 2017:

"a traumatised man who presented in consultation in a manner entirely consistent with an individual suffering from severe symptoms of Major Depressive Disorder (severe) with additional symptoms of (complex) PostTraumatic Stress Disorder (moderate-severe). His suicidality is particularly severe and acute" (Thomas Report paragraph 207)."

He was by 4th May undertaking frequent attempts at suicide, usually either by trying to hang himself or slit his wrists (Thomas Report, paragraphs 153, 160, 163).

He was also subjected to abuse by guards on at least two occasions evidenced on video footage while in detention and traumatised by those experiences. D1527 himself points to further incidents both in Brook House and beforehand in HMP Belmarsh in which he had been abused by guards and also recounts a history of physical abuse prior to detention.

Dr. Thomas explained at paragraph 162 of her report on 31 May 2017 that D1527 was suffering from psychotic symptoms in detention:

"if he remains much longer in his current situation... not only is [D1527] likely to be successful sooner or later in ending his life but... even if not, his psychotic symptoms are indeed likely to intensify and worsen, making the likelihood of a psychotic breakdown and the development of a schizophrenic illness a real possibility" (paragraph 187 of her report).

Shortly after this report was prepared a claim was issued in the High Court seeking an order directing the release of D1527 and this was granted on an urgent basis. The relevance of D1527's mental illness and psychosis is threefold:

Q. First, there is a legal question as to whether standards as to the use of force are appropriate for psychotic and mentally ill detainees. Mr Collier's determination that the assault- or use of force on 4th May was lawful is peremptory and we are also concerned that it is outside his field of expertise. It seems to us that lawfulness is a legal question and therefore not a matter on which Mr Collier is qualified.

I have not determined that force was lawful. I referred to the relevant DCR as listed on the UOF documents as the reason why force was used. I cannot comment due to my lack of knowledge on the legalities of using force, as defined within the approved training manual, in the case of being appropriate for a detainee with mental illness.

Q. Second, working on the assumption of lawfulness, we agree it is nonetheless pertinent to ask if the use of force was necessary, reasonable and no more than proportionate. Crucial to that assessment is a recognition of the mental illness of D1527. As set out above, he was likely psychotic, suffering from a major depressive order as well as PTSD not only from historic experiences but from recent trauma inflicted by staff at the detention centre. There does not appear to be any accommodation of those factors in Mr Collier's report when considering what interventions were reasonable or necessary.

I did not have any information or knowledge of D1527s mental illness or did I have any reason to consider it within my review of the incidents involving D1527. I was aware that he has self-harmed but this was the extent of the information I based my findings on.

Thirdly, and related to that, it would seem that the decision to move D1527 to E-Wing as one which is itself of dubious legality or justification. It appears that the consequences of removal of him to that wing were not thought through, reasoned, justified or properly authorised in the circumstances. In

particular no consideration seems to have been given to his mental illness, his particular terror of being put on that wing, or that that was a location for abuse of him by guards (as shown in video footage and explained in his evidence).

Written Response to Rule 9 Questions

On behalf of D1527, our firm has made detailed submissions in the 'Written Response to Rule 9 Questions' which sets out why we believe the decision to segregate D1527 and to use force to transfer him to E-wing on 4 May 2017 were both unlawful. As a starting we ask that Mr Collier review the Written Response to Rule 9 Questions which set out D1527's position on the incidents. These are set out in detail in responses to Questions 47-48 (pages 33-56), Questions 66-67 (pages 73-87) and Question 112 (pages 115-117). These should be considered alongside D1527's account in his witness statement at paragraphs 68 to 79.In our view, having reviewed and understood the position, it will be necessary to revisit the starting point in paragraph 268 that "D1527 was to be relocated to E-wing" and "due to his actions he was to be relocated".

Specific Issues on Mr Collier's Findings

We provide the following questions in chronological order in respect of the events of 4 May 2017.

Mental Health and Vulnerabilities

Q. 1. We ask that Mr Collier more generally reviews his findings as to the justification, necessity and proportionality of the decision to segregate D1527 and use force to transfer him in light of the additional documents provided. In particular, we would ask that he consider the relevance of D1527's known vulnerabilities and mental health issues.

I am unable to comment further as I have no knowledge of any alternate methods for specific mental health conditions.

Q. 2. Should D1527's mental health issues have been a consideration when decisions were taken to move him to E-wing? Such considerations are largely absent from the Rule 40 decision (HOM000251) and use of force reports (CJS005530). In particular we ask Mr Collier to note the following known factors:

I am not an expert in deciding the most beneficial location within a custodial setting for those with mental illness.

a. D1527 was a known suicide risk who had made serious self-harm and suicide attempts whilst in E-wing (the proposed location of transfer) as evidenced by the previous events of 25 April 2017 (addressed by Mr Collier as incident 105/17). He was on constant watch whilst there such was his risk (CJS005997_0038). It was only once returned to general association that healthcare noted an improvement in respect of this risk (see entry by Karen Churcher – 28 April 2017 – 14:15 – CJS005997_0038). His suitability in being transferred to E-wing where he would be deemed a significant suicide risk should have been a highly relevant factor.

b. D1527 was diagnosed with PTSD by in-house psychiatrist Dr Belda just two days earlier on 2 May 2017 (CJS005997_0042). There is no evidence that this recent diagnosis was considered by the team led by DCM Dix in the decision to segregate or use force to transfer him to E-wing and what the mental health consequences would be. This is despite mental health nurse Karen Churcher being both present

during the PTSD assessment on 2 May 2017 and the transfer to E-wing on 4 May 2017. The only mental health consideration appears to be one in which he is deemed more of a threat to officers.

c. D1527 was on day 5 of a food fluid refusal at the time of the events of 4 May 2017. As confirmed in his witness statement at paragraph 69DL0000144_0025), D1527's intention on this day was to end his food refusal and he went to the welfare office to request a plate for dinner. He was wrongly accused by DCO Precious Okolie Nwokeji of having eaten earlier in the day and refused assistance. This led to an escalation of D1527's frustrations that ultimately led to him being on the netting. DCO Nwokeji went on to mock D1527 during his protest calling him "a bitch because he was told about a plate" (KENCOV1012 – V201705040021). His mental health nurse Karen Churcher would also go on to laugh about the incident and mock him ("If he didn't have to do the washing up, he didn't have to go that far did he... I don't know (laughing) it's a dirty plate" (KENCOV1012 – V201705040022 clip 2). The cumulative result of the actions of G4S staff on 4 May 2017 was that D1527 continued his food refusal until at least 7 May (CJS0059997_0044).

It is not within my remit or my knowledge base to give an opinion on the removal process, or the matter of compliance with the Rules, of a detainee under Rule 40.

<u>D1527's Protest on the Netting</u>

3. Mr Collier considers staff's handling of D1527's protest on the netting at paragraph 282 of his report. He finds that "The control of this incident was very poor... there does not seem to be any incident control or thoughts on how to resolve the matter. By allowing the detainees to remain unlocked it made communication very difficult and provided numerous distractions to D1527".

Q. a. To what extent does D1527's known mental health and suicide/self-harm risk inform Mr Collier's findings on how his protest was handled?

My comments were more centred on the incident scene control. When considering D1527s mental health condition I am of the opinion that the scene control I identified would have been supportive to D1527 and allowed him to interact, without distraction, with a suitable person. By not giving him any personal attention, it allowed an increase in his frustrations and for him to be influenced/affected by those around him. By providing 1-1 communication it may have helped to alleviate some of the concerns, and at the time provide senior managers with a greater understanding of the individual needs and the lengths he was prepared to go to.

b. What concerns does Mr Collier have about the following comments made by individual staff members during the protest and what it might say about the level of professionalism each applied in dealing with D1527's protest and his clearly acute mental health crisis:

i. DCO Precious Okolie Nwokeji referencing D1527: "[inaudible] a bitch because he was told about a plate" (KENCOV1012 – V201705040021). This was the welfare officer D1527 approached to seek a plate for food to come of his food refusal.

ii. Officers in general failing to challenge 'Detainee 1' singing 'I believe I can fly' in reference to the fact D1527 might jump ('fly') and try commit suicide (KENCOV1012 – V201705040022).

iii. DCO Clayton Fraser when asked about the best way to deal with D1527: What Yan did (laughs)" (KENCOV1012 – V201705040022 clip 2). This is in clear reference to the torture on 25 April 2017.
iv. DCM Steve Dix when asked by Callum Tulley about what if D1527 attempts to jump off the netting: "Oh well, its his own choice innit" (regarding (KENCOV1012 – V201705040022 clip 2). DCM Dix was the manager in charge of the response to the protest, made the decision to apply Rule 40, and to use force to transfer D1527 to E-wing. We are highly concerned DCM Dix approached his actions towards D1527 without any sympathy or concerns to the risks to his physical or mental health which this comment appears to support.

v. Mental health nurse Karen Churcher: "If he didn't have to do the washing up, he didn't have to go that far did he... I don't know (laughing) it's a dirty plate" (KENCOV1012 – V201705040022 clip 2). Karen Churcher was not only D1527's mental health nurse and aware of his recent PTSD diagnosis, but was the responsible nurse assessing D1527's health during the use of force on 4 May 2017.

At is concerning that staff demonstrated an unsympathetic view toward D1527 during this incident. I have taken into consideration the pressure on staff at the time, it is documented that the centre was understaffed and that incidents had increased. This does not mitigate the comments, especially those of DCM Dix and Nurse Churcher. Ideally a mental health nurse could have been used to try at persuading D1527 to come off the netting, or at least inform the command suite of the best lines of communication and strategies for a person with mental illness during a highly charged incident.

The Rule 40 Decision

4. The following questions are provided with the caveat that we understand that Mr Collier is not an expert in the use of segregation in the IRC context but has nonetheless addressed issues of segregation in his report.

Q. a. Paragraph 289 of his report states his view that the use of force was lawful by reference to "Rule 40(1)", however Rule 40(1) only states that the SSHD or manager "may arrange for the detained person's removal from association", it does not give lawful direction to do so by force. Is it within Mr Collier's expertise to determine that a use of force is lawfully authorised pursuant to rule 40?

I have not determined that force was lawful. I referred to the relevant DCR as listed on the UOF documents. I cannot comment due to my lack of knowledge on the process within an IRC for removal of a detainee.

5. Can Mr Collier consider his view of the authority under rule 40 in view of the following factors:
a. The Rule 40 decision (HOM000251) was authorised by DCM Steve Dix at 17:45 on 4 May 2017 for an initial 24 hours as a 'case of urgency' with the following explanation for the decision:

"Detainee D1527 has been relocated to Care and Separation Unit on rule 40 after jumping on Delta Wing netting. Mr D1527 removed himself after approximately 30 minutes, he went to a friend's room to calm down...Further background is provided by DCM Dix in the DCF2 Use of Force report CJS005530_0008) that is not recorded in the Rule 40 decision:

"...I Detention Custody Manager {DCM} S Dix was working at Brook House IRC on Thursday 04/05/2017 at roughly 16:30 when I attended a first response call to D wing. Upon arrival I saw detainee D1527 on the first floor netting who was shouting in his own language and very irate. Mr D1527 refused to engage with any staff members really and other detainees tried to engage with him to which he did. After a short while he agreed to come off the netting but only if there was no staff around, I agreed to this as detainee D378 and D812 were talking to him once D1527 was off the netting he went into their room to calm down. I have gone to speak D378 and D812 after this incident for a post care de-brief and they are both happy with what they witnessed and understand the necessary actions taken.

A short while later I went back to that room to speak to D1527 about his actions he was frustrated with staff members but I tried to explain the they could not leave him alone was because of the way he was behaving. I explained due to his behaviour he would need to comply and go to the CSU on rule 40 he said "No""

Rule 40(1) only permits the use of removal from association where it is "necessary in the interests of security or safety". Rule 40(2) only allows an IRC manager (as opposed to the Home Office) to authorise removal from association in "cases of urgency".

With the above in mind:

Q. b. Does Mr Collier agree that DCM Dix in fact gives no reasons as to why it was "necessary in the interests of safety or security" to move D1527 to E-wing? He simply states the decision was because he jumped on the netting and due to his "actions" and "behaviour" – he does not link to how being placed on Rule 40 was a necessity to protect the safety or security of the centre.

I am not able to comment on the application of R40 in these circumstances within an IRC as it is outside of my knowledge base. I can comment on the procedure that would have applied in a similar situation within my experience in a custodial setting.

At any time following an act of disorder, and a protest on the netting is defined within the incident reporting system as such, the person would be relocated to the CSU awaiting a decision on how to proceed. This would be due to the risk of a similar action at the next opportunity. Incidents on the netting cause a disruption to the normal regime and it must also to be considered under the Health & Safety Guidelines to take necessary preventive actions in order to avoid further protests of this kind.

The netting is not designed as a working platform, it is an engineered system designed for arresting falls from height purposes, and nothing else.

Therefore NO S.W.L is quoted for this as it is not designed for the purposes of supporting superimposed loading, other than that which results from its design purpose. No loading testing is therefore necessary or indeed appropriate. It is designed to absorb the instantaneous impact dynamic loading of a single body falling from heights up to 7.5metres and to prevent the life threatening injuries to the spine and neck area due to the gravitational forces exerted in these body

areas when a fall occurs. No other access onto the nets should be allowed as the wire welding, netting support clips and springs can be seriously damaged by these actions. Suitable staging supports, Youngman scaffolding or other suitable support structures providing access across from landing floor positions and other appropriate safety procedures are required if access to the safety mesh area is necessary for any other purposes. If inappropriate access onto the mesh has occurred, the wire mesh and all its fixings springs etc. have to be fully inspected to ensure that no damage has occurred, if damage has occurred replacement of parts may be necessary. Regular Inspections of netting in any case at a minimum 6 monthly intervals should be part of the procedural orders set up at this time as previously notified. Information provide by National Offender Management Service-Custodial Property-Technical Services

c. Note that rule 40(6) requires a detainee to be given formal written reasons. Does Mr Collier agree that none were given (at least within the two hour requirement)? What is Mr Collier's view of that failure and what is its consequence for his view of the claimed justification for the use of rule 40?
d. Does Mr Collier believe that DCM Dix has satisfactorily demonstrated in his decision why this was a case of urgency thus permitting him to make the Rule 40 decision without the need for approval from the Home Office? On DCM Dix's own evidence, it appears that he had in fact de-escalated the situation by allowing D1527 to come off the netting and thus removed any on-going security or safety risk. He successfully negotiated for D1527 to come off the netting by removing staff from the scene and allowing detainees D378 and D812 to move him safely to their room. By DCM Dix's own version of events D1527 had calmed down. There was no longer any urgency. Instead DCM Dix took a unilateral decision to use Rule 40 – his decision and the necessity and urgency must be taken in these circumstances. DCM Dix's decision to segregate only served to escalate the situation, resulting in use of force –whether the use of force was lawful or unlawful (we say clearly unlawful), the decision to move D1527 to Rule 40 only served to increase the risk of safety and security to both D1527 and staff in that use of force

e. Does Mr Collier agree that the Rule 40 decision takes no consideration of the mental health risks to D1527 in removing him from association?

f. Why does Mr Collier say D1527 was removed "due to his actions" (paragraph 268)? Why would the person's actions lead to them being removed under rule 40?

My previous answers address these questions.

<u>The Initial Use of Force in the D-Wing Cell</u>

Q. 6. Can Mr Collier explain his approach to resolving conflicts of evidence or factual disputes in making his judgments as to what happened and therefore as to the basis for assessing use of force? The following detail is relevant in this regard. At paragraph 269 Mr Collier says that "DCM Dix was met with an act of non-compliance". That appears to reflect an uncritical acceptance of the account given by DCM Dix. Would Mr Collier consider the facts that DCM Dix was already found by G4S to have made failures as a DCM to investigate and properly follow up on the assault against MA on 25 April (CJS004302_0005) and was captured by Panorama footage, in the build up to the use of force against

MA on 4 May, giving entirely unsympathetic and highly offensive comments about MA and his suicide risk ("oh well").

I can only base my findings on the evidence presented, in this case CCTV footage from outside of the room and staff UOF statements. From the CCTV footage there is a period of time between DCM Dix entering the room to the staff stood outside entering and D1527 then being seen to be under restraint. I can only base my findings on the specific incident being reviewed and not considering previous incidents or events.

Q. 7. To what extent should D1527's mental health have informed DCM Dix's assessment of "non-compliance"?

The current training does manual does not include specific guidance on managing UOF incidents or communication strategies involving detainees with mental illness. If any local training had been provided then this should have been a consideration for DCM Dix but I cannot find any evidence of any such training.

8. At paragraph 270 of the report, Mr Collier finds that it is "unacceptable that although DCM Dix had considered this would be a problematic engagement with D1527 based on him taking three additional staff with him and following the events earlier on that day, that DCM Dix did not activate a BWVC." DCM Dix has stated on the DC Rule 41 form (CJS005530_0001) that the incident was unplanned. We would be grateful if Mr Collier could address the following:

Q. a. If it was unplanned, is this an incident to which rule 43(2) of the Detention Centre Rules 2001 applied? If so, having regard to that rule:

Despite what is recorded this started as a DCM giving an Instruction to a detainee that then escalated into a UOF. The footage shows that staff were assembled outside of the room in which DCM Dix entered. Knowing the potential for non-compliance I assume DCM Dix assembled the staff in the event of non-compliance and for force to be used for the removal. Under normal circumstances any such conversation would not have had the additional staff positioned outside. Without any day-day management experience within an IRC I cannot comment on the application of R43 (2) or the procedures used at the time.

i. Was force authorised by the manager?
ii. Was it reported without delay to the Secretary of State after giving the order?
iii. Was notice given to a member of the visiting committee without delay?
iv. Was notice given to the medical practitioner without delay?
v. Was notice given to the manager of religious affairs without delay?
vi. Did the medical practitioner inform the manager of any reason why the detained person should not be put under special control or restraint?
Were any such recommendations put into effect?
vii. If, as the evidence suggests, these measures were not taken, what is
Q. Mr Collier's view of those failures?

b. Should this incident have in fact been deemed as a planned incident given that the use of force was foreseen and foreseeable: :
i. This was a planned transfer to take him to E-wing following a protest on the netting and so DCM Dix presumably had given thought to what would happen if D1527 did not want to go voluntarily;
ii. DCM Dix himself had considered it would be a "problematic engagement" and so took additional staff with him;
iii. D1527 was a known self-harm risk.

In my opinion and this is based on my observation from the CCTV and supporting documents, this was a planned incident. Additional uniformed staff had been assembled and the objective was for D1527 to be removed, using force if all other efforts were unsuccessful. My observations from viewing several incidents lead me to the conclusion that the perception within the centre at the time was that only if staff had been equipped in full PPE would an incident be deemed planned. This is not the case, an incident as observed on this occasion, is a planned UOF and should have been managed as such. Even if force had not been required it is still a requirement to plan and prepare as listed within PSO 1600. Many planned removal incidents, with staff in PPE, are actually resolved without the need for force, de-escalation or persuasion resolving the situation.

c. If this was in fact a planned incident, what other safeguards (in addition to the use of a BWVC) would you have expected should have been in place during DCM Dix's engagement with D1527 in his D-wing cell? E.g. would you have expected a healthcare member to be present? CCTV shows Nurse Karen Churcher does not arrive until D1527 is removed from the cell.

A planned incident should be managed as per the guidance in PSO 1600. This would include the attendance of healthcare staff and for the incident to be recorded on a handheld device. All staff involved would be included within a recorded briefing, which should also cover any specific knowledge of the detainee and any health/pre-existing injury risks. Post-incident a recorded debrief should take place and staff given the opportunity to raise any issues, concerns or state any injuries from the incident.

d. What other safeguards would you have expected in this scenario to take account of the fact that D1527 was highly vulnerable, a self-harm risk and mentally unwell?

I would have expected information on previous incidents involving D1527, including self-harm. If the mental health issues were known they should have been included within the briefing. If force was a foreseeable likelihood any specific guidance should have been covered, however there is little guidance available at present on how to use force for those with specific issues.

e. Why is the failure by DCM Dix to use a BWVC and the failure to treat this as a planned incident not listed in Mr Collier's 'Areas of Concern'?

I accept that it should have listed in my areas of concern. I have addressed the general lack of understanding between planned and unplanned and the wider use of BWVC in paras 647-649, and made recommendation 5 to reflect an improvement plan for the centre.

f. Has Mr Collier read the account given by D1527 of the incident? Please see his witness statement and the Rule 9 responses given by D1527.

9. Please could Mr Collier reconsider paragraph 285 in which he opines that the initial use of force appeared necessary and proportionate.

Q.a. Is this based on accepting DCM Dix's account at face value? What if the chair upon hearing evidence takes the view that his account giving the appearance of a spontaneous and reasonable use of force is not to be taken at face value?

I only formed an opinion based on the evidence from staff and the external CCTV footage.

Q. b. Is a speculation based on a person putting their hand in their pocket a sufficient basis for use of force in the case of D1527 who did not have a history of assaulting officers?

Any assessment of risk is based on the individual perception at the time. DCM Dix is the only person who can comment on why he felt this to be such a risk that force was necessary. Just because there is no history of violence toward staff the decision making must consider the potential risk, bearing in mind there is always a first time for such actions.

The following quote is used during many HMPPS training courses for decision making- *A decision is defensible if, in spite of a negative outcome, it can be demonstrated that all reasonable steps had been taken in its assessment and management.* CPS guidance states that *"a person defending himself cannot weigh to a nicety the exact measure of his defensive action".* CPS guidance says "that evidence of a person's having only done what the person honestly and instinctively thought was necessary for a legitimate purpose constitutes strong evidence that only reasonable action was taken by that person for that purpose." This is relevant because it puts the action of going onto the netting into context - it is as much a health and safety risk as it is a discipline matter.

Q. c. What account should have been taken of D1527's mental illness and his particular terror of E-Wing as described in his witness statement?

As previously stated DCM Dix would have based his assessment on the risk and if he did have knowledge of D1527s mental illness it should have been considered and factored, and recorded, on his decision making.

10. At paragraph 271, Mr Collier reports the following as a factual summary of what happened inside the D-wing cell when initial force was used: "Once confronted by the potential threat DCM Dix, after trying to explain the reasons for the move, initiated force and then removed himself whilst the three other staff applied the control. DCM Dix then applied handcuffs to D1527." Can Mr Collier confirm why he has taken the account of DCM Dix at face value when that is a matter in issue?

Yes, no other evidence available to me at the time.

11. Has he had regard to the fact that both DCM Dix's reasons for the initiation of 'spontaneous' force (i.e. that three was a threat because he did not know what D1527 had in his pocket), and was as to what force was used (as set out in paragraph 271) are both contradicted by the accounts of all others present. Please can Mr Collier engage in detail with the contradictions in the reports of all officers so as to assist the chair when hearing oral evidence:

 DCM Dix: As stated above, DCM Dix claims that D1527 placed his hands in his pocket, Dix asked him to empty his pockets and he refused. Force was therefore immediately used by Dix by controlling D1527's right-arm, getting it into a back hammer before handing over to DCO Yates once officers came to assist.

 DCO Yates: "Once in the room DCM Dix began talking to Mr D1527 about what had happened and explaining that we would need D1527 to escort us down to Eden wing until the matter had been fully investigated. At the point Mr D1527 said something along the lines of "Go get your friends to get me I am not going anywhere". At this point Mr D1527 put his right hand in to his pocket and looked to be reaching for something. DCM Dix asked Mr D1527 what was in his pocket and asked Mr D1527 to remove his hands from his pocket and place them by his side. Mr D1527 responded with "You'll see what is in my pocket" he then stood up with his fists clenched and started shouting. DCM Dix then grabbed hold of Mr D1527 right hand. At this point DCO Bromley and DCO Sheharyar Shaukat entered the room and began to restrain Mr D1527. I took the right arm of Mr D1527 and isolated his arm to the small of his back." (CJS005530_0018)

 Please would Mr Collier consider the following inconsistencies: o Yates adds that D1527 was telling Dix to get 'his friends' (i.e. the officers outside) when Dix only says D1527 said 'no' in response to walking compliantly o Yates claims that in response to Dix asking D1527 to empty his pockets, D1527 says: "You'll see what is in my pocket" and that he then "stood up with his fists clenched and started shouting" – This is entirely inconsistent with Dix. Dix states D1527 refused to show what was in his pocket and refused to remove his hands from his pocket and so Dix used force immediately against D1527 without D1527 doing or saying anything further. Yates's comment suggests D1527 was threatening officers with what is in his pocket, before clenching his fists and appearing like he was about to attack the officers.

o Yates suggests Dix took hold of D1527's right hand (Dix says he took hold of right arm before putting into back-hammer then handing over to Yates) then Bromley/Shaukat came in and restrained D1527 before Yates took the right arm and isolated it to his back. Dix suggests he handed D1527 over to Yates before the other officers were involved. This is all inconsistent.DCO Shaukat: "At Approximately 17:23 I DCO Shaukat and DCO Bromley entered the room, due to the loud aggressive tone Mr D1527 was using towards DCM Dix. DCM Mr .Steve Dix asked Mr D1527 for his cooperation on more than one occasion. Mr D1527 was not willing to cooperate he then stood up from the bed he was sitting on in an aggressive manor with both fists closed and tried to reach for his right pocket while trying to swallow his phone which then fell off. I... then took control of Mr D1527 head inside the room. Officer two and three then took control of Mr D1527 right and left arm, as soon as they had locks on." (CJS005530_0011)Again this version of events cannot be reconciled with DCM Dix's statement or

Yates:

o Shaukat confirms he and Bromley entered the cell whilst negotiations were still going on because D1527 was said to have a "loud aggressive tone". Dix says they arrived after he initiated force ("before handing it over to DCO M Yates once officers came to assist").

o Shaukat says D1527 stood up off bed in aggressive manner with both fists closed and trying to swallow his phone. Again Dix does not mention D1527 being aggressive with his fists closed, Dix says hands were in pocket and refusing to show what it was. Shaukat suggests that D1527 may have been reaching for his phone and was trying to swallow it. If the item was clearly a phone this significantly undermines Dix's justification for force which is based entirely on not knowing what D1527 had and that it could be used to hurt D1527 or officers.

o Shaukat's account suggests he took force first by taking hold of D1527's hands before officers two and three (Yates and Bromley) took D1527's arms – there is no suggestion that Dix took hold of D1527 first DCO Bromley: ". At approximately 17:23 myself and DCO Shaukat entered the detainees room following hearing detainee D1527 aggressively shouting, upon entering detainee D1527 reached for his right pocket while trying to swallow his phone to which he didn't succeed and instead he dropped it onto the floor in the room by mistake. Immediately D1527 stood up from sitting on the bed in an aggressive manor with both fists closed insulting DCM DIX, and then reached for the phone for the second time. At this point DCO Shaukat took control on detainee D1527 head while myself took control of his left arm and DCM Michael Yates took control of his right arm". (CJS005530_0014) Again this is inconsistent with Dix's account:

o Like Shaukat, Bromley suggests he and Shaukat entered the following because D1527 was "aggressively shouting" and before Dix applied force.bromley states D1527 reached for his right pocket whilst trying to swallow his phone, did not succeed and instead dropped the phone. He then got off the bed "in an aggressive manor with both fists closed insulting DCM Dix and then reached for the phone the second time". This again cannot be reconciled with Dix's account and undermines the justification that Dix did not know what D1527 had in his pocket and so used force before D1527 could use it in case it was dangerous. Bromley and Shaukat's accounts suggest that the item was a phone, that he had gotten it out of his pocket and that Dix did not spontaneously use force on basis D1527 had hands in his pockets.

o Bromley confirms Shaukat took hold of MA's head first before he and Yates took the arms. He does not state Dix initiated the force then handed him over to Yates then the other officers.

 D1527: D1527 provides the following recollection in his witness statement:"75. When I was in the Palestinian detainee's room, a lot of officers came in. My recollections are that first DCM Steve Dix and Michael Yates came into the room and told me that I had to go to E Wing. After a while, Steve Dix asked for other officers to come in, who I understand to be Ryan Bromley, Mohammed Shaukat and Ben Wright. I know these names after having reviewed footage and disclosure with my legal Representatives. They said I had to go to E Wing and I said no. I have said above all the reasons I hated being on E Wing. I did not want to go with them. So they used force on me — there was no negotiation,

no 'de-escalation'. I had my phone in my hand. I think I may have said something like I might swallow it.

76. Ryan Bromley grabbed my arm and shoulder, and then Michael Yates grabbed my other arm and shoulder. This is what I remember happening, I remember the faces of the men who did this to me, and was only able to confirm their names after seeing the CCTV footage and discussing this with my legal representatives. I know that the Use of Force Reports say various things about who use force on me, but they all tell different stories, and this is what I remember. I know that Michael Yates used a lot of force on this day. He was very aggressive with grabbing my arm and twisting it behind my back. It was very painful, much more than just holding me to restrain me. I felt like he was being as hard as possible to deliberately hurt me.

78. I do not agree with what Steven Dix says in his use of force report, that I am going for something in my pockets. I did not have my hands in my pockets at any moment. I do not agree with him when he writes that he told me to take my hands out of my pockets and that I refused and said no. My hands were not in my pockets, which you can see from what the other officers have said in their report. If my hands were not in my pockets, I could not have refused to take them out.

Continuing force to transfer to E-wing

It is not uncommon for individual staff to have a different recollection and perspective of an incident. There is often contrasting descriptions to the most basic of facts, for instance who had the right arm and who had the left arm. The activation of a BWVC or a handheld device would have provided a greater degree of evidence of the events that occurred inside the room. The actual time in which staff complete their statements can also be a factor. There is a requirement for all UOF documents to be collated within 24 hours. This can lead to rushed and inaccurate accounts, especially when completed immediately post-incident. There is no room for reflective thinking and due to the urgency for competition staff often record only the most basic information. This is another area I address in my recommendations.

12. At paragraph 290, Mr Collier states of the decision to use force to transfer D1527 to E-wing: "all reasonable efforts through persuasion and negotiation failed and force was the last option available to facilitate the move." However this reasoning cannot be made out upon the basis of the reports produced by the officers. Can Mr Collier consider further whether force was the last option available accounting for the following factors:

Q.a. According to DCM Dix's account, the force used was spontaneous to prevent D1527 self-harming or harming officers with an unknown item in his pocket. When did that justification for force cease to be relevant? What was the justification to place D1527 in handcuffs and move him by force to E-wing?

The justification for the UOF to cease will be when it is no longer necessary or reasonable. In his statement D1527 confirms he refused to move to E wing. Staff can use force when all other efforts for compliance have not been successful. The use of handcuffs for the removal to E wing are in my opinion justified due to the previous incident and the potential risk of a repeat action. The use of

handcuffs will under most circumstances remove the need for restraining holds to be used and can allow the detainee to stand upright.

Q. b. Why were there no further efforts to de-escalate the situation or consider other options to transfer D1527 to E-wing once the risk of harm had been prevented? How was force "the last option available to facilitate the move" at this point?

This is not a question I can answer. DCM Dix is the only person who can provide his thought process and decision making at the time.

Other Officers Present

13. Mr Collier confirms in his report that he has considered the CCTV (Disk 41 05May 2017 1727 - CJS0073759) for the incident. The CCTV clearly shows that two other officers were present during the use of force, yet no report is produced to confirm their role and they are not mentioned in the reports of other officers. Can Mr Collier comment on this?

From the CCTV we have been able to identify DCO Ben Wright as one of the additional officers present. We cannot identify the other officer and so simply refer to him as a the '6th officer'. At 17:23pm (31:52mins into the CCTV clip) the CCTV shows four officers (Bromley, Shaukat, Wright and a further officer) all stood outside the D-wing cell – Dix and Yates are already in the cell at this point. Three officers enter the cell in turn – Bromley then Wright then Shaukat. The other officer stands outside looking into the open cell watching events.

A few seconds after Shaukat enters, Wright briefly comes to the door – says something to the unidentified 6th officer and points down the corridor, before re-entering the cell. The 6th officer continues to stand outside the cell looking in and appears to take no action based on what Wright says to him.

At 17:25pm (33:20minutes) one of the officers from inside the room (unclear who) can be seen passing something to the unidentified 6th officer. It's unclear from the quality of the footage if he keeps hold of the item or puts it in his pocket. It is unclear what the item is, e.g. whether it might be D1527's phone.

When the officers leave the cell, DCO Wright is not placing any holds on D1527 but is facing towards him and watching him the whole way whilst the unknown 6th officer walks in front.

The officers can be seen throughout the incident and in taking D1527 to E-wing and staying on E-wing whilst DCM Dix appears to de-brief the officers outside D1527's Ewing cell. Neither officer has produced a use of force report and neither officer is mentioned in the use of force reports of Dix, Yates, Shaukat and Bromley.

G4S' use of force policy dated March 2016 (CJS000360) states at section 9: "All members of staff who were involving in using physical force will record exactly what their involvement was on the Annex A

of the Use of Force report form. Any members of staff who witnessed the use of force incident will be instructed to complete an incident report; which will be submitted to the Use of Force Supervisor."

If DCO Wright or the 6th officer used force at any point, they should have completed a use of force report. It is unclear if DCO Wright was involved in the force in the D-wing cell but it is concerning that his presence is not referenced by other officers. What is clear is that at the very least DCO Wright and the 6th officer should have completed incident reports as witnesses to the force used by the other officers. These reports cannot be located on Relativity and there are therefore doubts that any reports have been completed by DCO Wright or the 6th officer. There are no references to such reports in the PSU investigation (nor any reference to the officers despite the CCTV having been viewed) the only incident report is completed by DCM Dix (HOM000319). Neither DCO Wright nor the 6th officer are mentioned in this incident report. The report is blank on the list of "staff witness(s)" (HOM000319_001).

Q. a. Please can Mr Collier provide his assessment on whether he believes DCO Wright and the 6th officer should have produced reports and whether he would have expected their presence (particularly Wright who was in the cell) to have been recorded in the reports of other officers? Please set out any other concerns that may flow from this

I was unaware until now of the G4S policy for incident witnesses, G4S' use of force policy dated March 2016 (CJS000360) states at section 9: "All members of staff who were involving in using physical force will record exactly what their involvement was on the Annex A of the Use of Force report form. Any members of staff who witnessed the use of force incident will be instructed to complete an incident report; which will be submitted to the Use of Force Supervisor."

"Any members of staff who witnessed the use of force incident will be instructed to complete an incident report; which will be submitted to the Use of Force Supervisor. "**Based on this information I would have expected both staff to have completed a UOF report. I can confirm that this is not mandated in other custodial settings. I agree with the G4S policy that any witnesses should record their version of the events as evidence for the UOF pack. Ideally all staff statements should record who else was in attendance and any role they played in the restraint. However in my experience this is often overlooked, in part to staff being unaware who else was there as they were task focussed at the time.**

Other Inappropriate Uses of Force during Transfer

14. At paragraph 273, Mr Collier notes: "DCO Yates states that due to D1527 pushing against staff during the relocation he applied a thumb lock. If so, he should have applied the correct procedure for the application of a pain inducing technique as described within the UOF training manual (section 7)" We request that Mr Collier provides further clarification and analysis of this:

Q. a. On what basis would such a thumb lock be justified and for such a thumb lock to be used?

The UOF training manual sets out the criteria for applying a PIT, of which a thumb lock is included,

"the use of a pain inducing technique may be justifiable if that is the only viable and practical way of dealing with a violent incident, which poses an immediate risk of serious physical harm to the prisoner, officers or others".
"Officers must be able to explain their reasons for using a pain inducing technique as part of their decision making process and be able to set out their approach in their subsequent use of force report".
Whenever possible officers should follow the guidelines listed below before applying any form of pain inducing technique:

- **Refer to responsibilities**
- **Prior to application use verbal reasoning – appropriate de-escalation dialogue**
- **Give the prisoner a clear, simple, verbal instruction of what is required – ensure they understand**
- **If they continue to refuse, give a clear statement that they are leaving you with few options i.e. one of those is that they may feel pain in a specified area**
- **Give a further clear, simple, verbal instruction of what is required**
- **Apply technique, and continue to give verbal instructions in a controlled tone (the application of pain with instruction is more likely to result in the prisoner following the instruction) – the pitch and tone is crucial – assertive not aggressive**
- **This technique should only be applied for approximately 5 seconds however circumstances may dictate that the application of pain may be required for longer.**

Whenever possible officers should follow the guidelines listed above prior to re-applying any form of pain induction
NB: It is accepted that in certain situations these guidelines will not be possible due to the immediate risk to officers, the prisoner or others. In these situations officers will give clear instructions, whenever possible, during the application of pain inducing techniques. Based on the description of DCO yates and the evidence from the footage where staff struggle once they reach the door the use of a PIT would be justified.

Q. b. To what extent should D1527's vulnerabilities and mental health be relevant to the use of pain inducing techniques and their potential effects?

c. Please take into account D1527's witness statement at paragraph 76 and his comments about the use of force by Yates and the impact on him

I based my findings on the evidence at the time. It would be impossible to comment on how D1527 felt following the restraint.

15. We ask that Mr Collier reviews another potentially unlawful use of force that we identified within the CCTV footage by DCO Shaukat during the transfer to E-wing where he appears to grab D1527's neck to move him through a doorway. Stills of the CCTV are contained in D1527's Written Response to Rule 9 Questions at pages 52-53:

This incident is briefly referenced in the PSU investigation but not investigated by them:

"7.83. DCM Yates noted that Mr [D1527] became more disruptive as they left the wing and he used pain compliance to get Mr [D1527 to continue to walk. This is corroborated by the CCTV footage which did not show the entire incident, but showed the other side of the door and part of the incident to confirm that the officers had difficulty in getting Mr [D1527] through the door. When Mr [D1527] was escorted through the door DCO Shaukat had taken control of Mr [D1527] head. Once in the corridor DCO Shaukat released this hold and Mr [D1527] was held by the arms by DCM Yates and DCO Bromley as they walked through the medical corridor and in the activity corridor. Mr [D1527] appeared to be resisting and shouting at the officers"

This incident appears to occur at the doorway out of D-wing and is not mentioned by DCM Dix, DCO Bromley nor DCO Shaukat in their report despite all being present. DCO Yates is the only officer who mentions a struggle and force being used at this point:

"We left the room and began walking.to the back exit on level one of Dove Wing. Just before leaving the wing Mr D1527 began struggling and pushed his way to the Wall. After a struggle I applied the thumb flexion/lock back onto Mr D1527 We then moved forward and made our way to Eden Wing."

As the PSU states, the entire incident cannot be seen on the CCTV. However what can be seen at 17:26pm (34:49 minutes into the CCTV clip) is that DCO Shaukat's hands are raised towards D1527. The PSU describe Shaukat as holding his head, yet Shaukat's hands can clearly be seen at D1527's neck area. DCM Dix, DCO Wright and the 6th unknown officer all have a clear view. DCO Bromley can be seen to be right behind D1527 (he is notably taller than D1527). D1527 then appears to fall back through the door at the impact of Shaukat's force. Shaukat then appears to be leaning down holding something or someone (presumably D1527) on the other side of the door. DCO Shaukat goes through the door back into D-wing followed by Dix with Wright and the unknown 6th officer waiting at the door. At 17:27, D1527 is brought Back through the door with Shaukat holding his head and Yates/Bromley holding his arms.

We refer to the report dated 6 February 2017 of Mr Collier on the use of force against D1527 in respect of events on 25 April 2017 (CPS000002). This discussed the force used by DCO Paschali in which his hands were around D1527's neck and Paschali's thumbs driven into D1527's neck/throat area:

"11... The footage clearly shows the hand position around the neck of detainee D1527 and the thumbs of DCO Paschali being driven into the neck/throat area.

12. There is a technique taught to staff known as the Mandibular Angle Technique (MAT). It is used as a pain-inducing technique for use in circumstances where other techniques are proving ineffective or if the risk of harm is so great immediate action is required. Prior to any pain-inducing technique being applied staff should where possible, engage in verbal reasoning, inform the detainee of what is expected of them, warn the detainee and attempt to manage the situation without applying pain. If pain is applied I t should not be for any longer than five seconds, although some circumstances may dictate longer. The application of this technique requires pressure to be exerted by the thumb through the point at the base of the earlobe. The technique used by DCO Paschali does not reflect the MAT

and it can in no way be interpreted as attempting to apply the MAT. The pressure used by DCO We believe Mr Collier should follow this approach to this instance with DCO Shaukat. DCO Shaukat's hands can be seen around D1527's neck. There is no force that would justify Shaukat taking D1527's neck. If Shaukat is in fact using the MAT then (a) the justification for its use cannot be made out on Mr Collier's guidance above, and (b) Shaukat has entirely failed to set out this incident in his report without any justification. An MAT appears to be a technique of absolute last resort –this clearly cannot be made out where D1527 is still under control from Yates and Bromley and there are 6 officers present to manage the risk.

Shaukat has clearly applied some further force, at least in the doorway – but his holding of D1527's head throughout the incident needs to be carefully reviewed -, but either he, nor Bromley or Dix records this incident. There are concerns that Shaukat could have grabbed D1527's neck. Regardless this instance of force should have been recorded by Shaukat (and Bromley and Dix) but was not. This is a significant failing by the officers that further undermine their evidence.

D1527 has also recorded the following of the incident in his witness statement at paragraph 77: "I remember DCO Shaukat grabbing me around my neck and dragging me through a doorway. He had my head all the way through his arm like in a headlock, and he used a lot of force on me. His arm was around my neck. It was very painful. I was forced down into a crouch, my back was bent down and they dragged me through the door and down the corridor. I have read the use of force reports and I can see that this was never recorded"

I have reviewed the section of the restraint where D1527 is taken form the unit into the corridor. There is a pause before staff appear with D1527 coming through the door. One of the officers has D1527 in the head support position. This is a prescribed technique to control the detainees head and protect it from being injured, examples would include when going through a doorway and the detainee is resisting. The officer places their forearm between the detainees head and the door frame to avoid any direct contact. I observed the head support being removed shortly after negotiating the doorway and D1527 being allowed to stand upright. In this type of instance I would have Instructed a member of staff to apply the head support for the H&S and well-being of the detainee. By lowering the head the ability for the detainee to use their legs to push against the door frame is removed, allowing a smoother process through this obstacle.

The technique used by DCO Shaukat consists of one arm cupping the chin and the other placed around the nape of the neck with the forearm protecting the side of the face. I understand how to the untrained eye this may appear to be excessive and almost like some kind of head lock, but my observation confirms that the technical application was correct and the use necessary and proportionate for the purpose of negotiating a move through the door whilst protecting the detainee.

Use of a Full Search

16. The Rule 40 decision by DCM Dix confirms that when D1527 arrived at his E-wing cell that "A full search was also conducted and nothing was found". DCM Dix's use of force report confirms the same:

"Whilst in Eden wing 008 a full search was conducted and authorised by DD D Naughton due to previous history of self-harm. Mr D1527 was asked to remove his t shirt this was searched and placed back on, he then removed his joggers and boxers these were searched and placed back on nothing was found during the search." (CJS005530_0008)

Reference is made to the Home Office's policy 'Detention Services Order 09/2012, Searching Policy'.2 Paragraph 8 of the policy defines a 'full search':"8. A 'full search' is a search of an individual that requires the removal and inspection of all clothing and footwear. The search must be conducted by two officers of the same sex as the individual and the individual must not be completely naked at any stage or in the view of others not involved in conducting the search."

Paragraph 32 of the policy stresses the following:

"32. Detainees must not be routinely subject to a full search. If there is evidence or intelligence to suggest that a detainee may be attempting to hide an illicit item about his or her person, then a full search may be authorised by the centre manager (or nominated manager in charge) or the escort supplier's duty manager. The local HOIE Immigration Manager or, a senior manager from the Escorting Contract Monitoring Team (ECMT) if the detainee is under escort or held at a STHF, must be notified in advance of the search taking place where possible or as soon as possible afterwards. It is not appropriate for a detainee to be searched twice by different suppliers for the same purpose on the same occasion."

Paragraph 49 also goes on to state the following in respect of those being moved to Rule 40 or Rule 42 accommodation:

"49. Detainees who are being separated from the normal regime should be Subject to a level A rub down search. Metal detecting wands/portals may be used, but detainees should not be routinely subject to a full search. If there is evidence or intelligence to suggest that an illicit item has been secreted, or following an individual risk assessment, then the centre manager (or nominated manager in charge) or escort supplier's duty manager may authorise a full search and the requirements at paragraphs 33-35 must be met."

In light of the above policy and what information has been provided by DCM Dix in his segregation and use of force reports, we ask that Mr Collier confirms:

Q. a. Whether he believes a full search was justified. The only claimed risk by DCM Dix was an unknown item in D1527's pocket. We are unclear as to how that could possibly result in the need for a full search and removal of D1527's clothes. Further the officers involved made clear it was a phone and their reports suggest D1527 dropped the phone in the D-wing cell. In the highly unlikely event that staff suspect he might still have it and could harm himself with it, it would have been picked up with a metal detecting wand

If D1527 was a known self-harm risk, and in order to protect him, a full search would be reasonable and in line with policy if an individual risk assessment had been completed. There must be solid

grounds for suspecting the presence of any item that may be used for an act of self-harm before carrying out a full search. A full search is often used in conjunction with the removal of clothing and replacement clothing being provided. However, I am unsure If this process was in operation at Brook House, or any IRC. The issue of sterile clothing removes any risk from illicit items, many of which can be concealed without detection.

Q. b. Was there sufficient evidence or intelligence to suggest that D1527 had an illicit item? The evidence suggested he no longer had his phone. Even if he still held his phone, it was not an "illicit item" – detainees are entitled to a
phone.

My view is that the risk was more around the self-harm issue. Having a phone is not an illicit item but the potential risk from any other items would be a consideration when deciding on the appropriate type of search.

A. this is an area where I do not have sufficient knowledge of the G4S procedures in place at the time or is it within my area of expertise. Even with additional information from security reports I would not be able to make any conclusions on the use of a full search.

Q. c. Can Mr Collier comments on why a full search is only used in such exceptional circumstances? D1527 found the search to be degrading.

Full searches are not routinely used and for most general security related searches rub down, handheld detectors and the use of a BOSS chair can adequately identify anything of concern. In circumstance where items may be concealed or when everyday items present a risk to the person or others a full search can be used to remove all risks in line with safer custody protocols.

D1527 Use of Force on 25 April 2017
UOF Incident log (not recorded - possibly 105/17) - D1527
Relating to 25/4/17 events

1. We note that Mr Collier does not list the staff involved. Was he not made aware of the staff involved?
2. Why does Mr Collier say at paragraph 33 that the "only" document for the incident and the "Only evidence I can use" to describe the initial section of the incident is the UOF report? There is for example a witness statement from D1527; his Rule 9 comments; and Dr Basu's reports all of which are inquiry documents. There is also the PSU investigation [CJS001107].

My comments are related to UOF documents only. There was a UOF report for the first part of the incident but the second part, involving Mr Paschali, was not recorded. I did not have either of the documents listed during my review.

3. The report does not note a key component of what happens in the incident. Yan Paschali whispers in the ear of D1527 that "I am going to put you to sleep you fucking piece of shit". It is that threat to

kill D1527 which, when then followed by being strangled, results in the particular panic and terror that is witnessed. In the context of D1527's history of vulnerability and of similar experiences, it can be seen how that triggers a traumatic episode. Please can Mr Collier address this.

I accept that I did not include this comment within my report. I did mention some of the dialogue used at the time of the incident. The statement "I am going to put you to sleep you fucking piece of shit" does not meet with the standards of professionalism expected of a DCO. They are threatening and intimidating and when combined with the position D1527 was in, with Mr Paschali having his hands on his throat, it is understandable that D1527 was fearful and panicked due to being in fear for his life.

4. At paragraph 51, can Mr Collier be invited to consider the language of DCO Charlie Francis? "Man or a mouse", "stop being a baby", "bored now" etc?

I consider the language used and the comments made unacceptable under any circumstance, let alone when dealing with a detainee during a difficult situation. They do not meet the professional standards expected of a DCO or others working on behalf of the Home Office. They would not assist in de-escalating the situation or give reassurances to D1527.

5. At Paragraph 47 there is a comment "lawful under Detention Centre Rules – rule 43 (1))". Can Mr Collier be asked to re-appraise that judgment? Rule 43 provides:

As with my previous comments the reference is to the reasons listed on documents not from my personal judgement. I have no knowledge of the local procedures in place at the time or if the removal under Rule 43 was compliant with the instructions listed.

(1) The Secretary of State (in the case of a contracted-out detention centre) or the manager (in the case of a directly managed detention centre) may order a detained person to be put under special control or restraint where this is necessary to prevent the detained person from injuring himself or others, damaging property or creating a disturbance

6. Is there evidence at all that either the Secretary of State or the manager ordered special control or restraint? Nor, it seems is there any evidence on which rule 43 (2) might be invoked. This provides:

(2) In cases of urgency, the manager of a contracted-out detention centre may assume the responsibility of the Secretary of State under paragraph (1) but shall notify the Secretary of State without delay after giving the relevant order

(3) Notice of such an order shall be given without delay to a member of the visiting committee, the medical practitioner and the manager of religious affairs.

(4) On receipt of the notice the medical practitioner shall inform the manager whether there are any medical reasons why the detained person should not be put under special control or restraint and the manager shall give effect to any recommendation which the medical practitioner may make

7. Can Mr Collier be asked to comment on the level of compliance with the matters set out in rule 43(2)-(4)?

Within my report I have not provided opinions on compliance with DCR, including Rule 43, as this is not within my remit or do I have any experience within the local processes in place at Brook House or any other IRC.

Annex 2 – Incident relating to D1914

UOF Incident log 134/17 — D1914
Detainee concerned: D1914
Date of incident: 27th May 2017
Reason for force as listed on the UOF report: failure to comply with removal, noncompliance, prevent self-harm
Staff involved: DCM Dix, DCOs Wragg, Paschali, Webb, Tulley, Bromley, Edon & Lake

D1914's own witness statement is almost complete for filing with the Inquiry and we would be grateful if this could be sent to Mr Collier once received.

1. To what extent has Mr Collier considered whether the removal attempt engaged necessary precautions regarding D1914's heart condition?

My opinion (para 124) is that very little consideration was given to the health condition of D1914 and in my opinion the presence of staff in full PPE was not necessary. There was little engagement at the door and staff entered almost straight away. If DCM Dix had paused at the door an taken the time to observe D1914 he would have seen the same situation as I have, a man who appears not to be in the best of health. Para 114 of my first report covers the briefing to staff from DCM Dix, where he mentions the triple by-pass operation D1914 was given. This should have been a key consideration.

2. A key consideration is that a doctor's note indicating that D1914 was fit to fly and fit to be detained. Is Mr Collier able to comment on the concepts of being "fit to fly" and "fit to be detained"?

My experience of this instruction would amount to the similar medical evaluation for the transfer of a prisoner. A 'fit to fly' assessment would be the medical officer's assessment that the person did not have any medical reason not to fly and could be escorted in order to be removed from the UK. I am not entirely sure on the terminology 'fit to be detained' as D1914 was detained at the time.

3. At paragraph 107 Mr Collier notes that DCO Paschali also mentions that he heard D1914 was going to obstruct staff and fight them. No other statements contain this information. Would Mr Collier consider commenting on this apparent falsehood in the records?

Mr Paschali mentioned this in his statement, hence why I noted it in my report. It is quite possible that others did not hear the comment or did not feel it was necessary to include within their own account of the incident. Ultimately a UOF report is the individuals account based on their knowledge and recollection of the incident.

4. In relation to paragraph 116, could Mr Collier consider whether the test of last resort also applies to whether officers should have considered whether the risks D1914 presented could have been mitigated

without the need for transfer? E.g. he could have been placed on observations in his own cell to mitigate the self-harm risk?

Due to a Home Office removal order the expectation on the Director of the Centre would be to comply with the order. Staff acting on behalf of the Director could consider where to locate a detainee prior to removal, but to ensure the detainee is removed. Using force to facilitate the removal is covered in DCR 43 (10).

5. In relation to transfer to paragraph 120, – could the risk of disruption/self-harm have been mitigated without need to transfer to E-wing?

This would have been a local decision and based on whether observations could have taken place whilst remaining within the general population.

6. In relation to paragraph 121, is Mr Collier surprised to learn that he was placed under Rule 40 segregation for 'refusing to relocate to Eden wing'? (CJS001064_0011). Does he have any immediate concerns regarding this? – "D1914 was placed on Rule 40 to maintain good order and discipline of the centre." –

My only surprise is that after observing D1914s health condition that it was not a consideration to locate him in the healthcare unit, especially if a constant observation was necessary. I am not aware of the availability of constant observations within the healthcare unit at Brook House but generally they have the facility to carry them out. There was no information that I was provided that indicated D1914 offered a threat to the Good Order or discipline. The only possible concern was over the risk of him self-harming. This would be a removal under DCR 43 (1).

7. What is Mr Collier's view of compliance with rule 40(6)

It was never included within my Letter of Instruction to review the documentation for removal under Rule 40. I simply stated the reasons as documented on the UOF reports.

Annex 3 – Incidents relating to D1538

UOF Incident log 142/17 — D1538
Detainee concerned:: D1538
Date of incident: 6th June 2017
Reason for force as listed on the UOF report: Good Order and Discipline, fight with another detainee
Staff involved: DCMs London & Farrell, DCO Bromley

D1538 is close to finalising and submitting his Rule 9 witness statement. We ask that be provided to Mr Collier once in final form. We ask that you also provide him with the full psychological report of Dr Rachel Thomas. The Inquiry has only so far released extracts of that report (e.g. DL0000057). The whole report should be made available and has previously been provided by Duncan Lewis to the Inquiry.

Mr Collier references reviewing covert footage from Callum Tulley called "KENCOV000073". We do not recognise this reference. It may be an error and ask for clarification that Mr Collier has in fact viewed KENCOV1031 – V2017060600011, and the accompanying transcripts at TRN0000089. Mr Collier should also be provided with the following transcripts and footage which record Mr Tulley's response to the incidents on 6 June 2017 - TRN0000066, BBC000624 and TRN0000064, BBC000622.

In addition we understand that Mr Collier had the use of force reports for incident but he does not appear to review the accompanying security incident reports (HOM004133) which also includes a statement from the arts and craft teacher, Sarah Walpole. This should be provided to him

We have significant concerns regarding Mr Collier's assessment that the force used by DCM Shane Farrell during this incident on 6 June 2017 was "was necessary and when applied only with the proportionate amount, and for no longer than necessary". All involved accept that D1538 was the victim of an attack by the other detainee involved (D197),1 and a police report was filed on the incident (SXP000033).

We request Mr Collier to address the following:

1. At paragraph 410, Mr Collier states that this incident involved a "lawful application of force to stop an incident continuing and possibly escalating" and that "Staff only used low level techniques and head support was for the safety of D1538". We ask that Mr Collier reassesses his findings that the force was proportionate, low level and lawful taking into account the following:

a. D1538 was the victim of an assault by D197. He may have been frustrated when officers arrived but the absolute minimum force necessary should have been used to control him. There was no further reasonable justification for DCM Farrell to take hold of D1538's head when it was clear that DCM London and DCO Bromley had him under control.

The statement of DCO Bromley states 'to protect the detainee from throwing his head back and forth'. DCM Farrell states 'thrashing his head all over the place'. It must be taken into consideration that a restraint involves three staff- one controlling the head- one officer on each arm. This is the training staff receive and applies to unplanned and planned incidents. As DCM Farrell arrived in response to the incident he would have been required to make an immediate decision, and follow the training provided to him. The following quote is used during many HMPPS training courses for decision making- ***A decision is defensible if, in spite of a negative outcome, it can be demonstrated that all reasonable steps had been taken in its assessment and management.*** **CPS guidance states that** ***"a person defending himself cannot weigh to a nicety the exact measure of his defensive action".*** **CPS guidance says "that evidence of a person's having only done what the person honestly and instinctively thought was necessary for a legitimate purpose constitutes strong evidence that only reasonable action was taken by that person for that purpose." I am therefore remaining with my opinion that the force used was proportionate (3 staff and restraints removed shortly after), low level (guiding holds and head support) and lawful (to prevent harm to other, risk of injury).**

b. DCM Farrell grabbed D1538's head twice despite being aware that D1538 had head injuries. This is confirmed by Farrell himself in his use of force report: "As I released his head the nurse came over to check on his as he had cuts on his neck and his eye was red from where had been hit by the other detainee"(CJS005615_0012). Farrell's knowledge of D1538's head injuries made the decision to grab D1538's head as even more risky and disproportionate.

There was a second application of the head support. If the honest held belief was that there was further risk from D1538 then this may have been a contributing factor in re-applying the head support. It is not clear form the footage the degree of the injuries sustained. When considering the initial assault-fight involving D1538 the injuries would be consistent with what happened. The nurse would have administered medical attention once the injuries were observed. I cannot comment on why this did not take place.

c. *At paragraph 406, Mr Collier states that "the head support position" was used because "D1538 started to struggle and could have caused injury to head". However DCM Farrell confirms that the reason he applied force was based on the risk of D1538 hitting his head on a filing cabinet: "I decided to take control of D1538 head as he was close to a cabinet I decided to apply head support so that he didn't hit his head on the cabinet and to protect the officers" However the CCTV footage shows that D1538 was in no danger from the filing cabinets which were several feet away. It was actually Farrell forcefully grabbing D1538's head that moves him towards the filing cabinets.*

The use of the head support is to provide protection to a detainee when they are struggling, or when the restraint takes place in an enclosed area and the risk is from the head hitting objects or being used against staff (head-butts- either intentional or accidental collision). Controlling the head reduces the movement of a detainee and allows controlling holds to be secured.

d. Mr Collier describes at paragraph 410 as the force helping to prevent the incident "possibly escalating". However DCM Farrell's report actually shows that his unnecessary use of force on D1538's head did nothing but inflame tensions: "D1538 was not happy with this and told me to Fuck off and

not hold his head. I tried to explain to him that I was doing this for his own safety and he was thrashing his head all over the place and he could risk harm to himself and the officers that where restraining him. He didn't seem to relax and the officers told me that they could feel him resisting there holds"

Controlling the head reduces the movement of a detainee and allows controlling holds to be secured. By gaining control the incident can de-escalate more effectively but, on this occasion, D1538 continued to resist staff. I disagree with the comment that this was an unnecessary UOF as D1538 did not calm down and staff used the approved techniques for restraining a detainee.

e. It may be that the level of force used by DCM Farrell is difficult to assess based purely on viewing the footage itself. However it is clear that multiple witnesses had concerns about the excessive level of force Farrell used which indicates this was not simply applying "low level techniques and head support":

i. A detainee witnessing Farrell grab his head: "279 [Shane Farrell grabs D1538's head and pushes it down while he is still 280 being restrained by Ryan Bromley and Nick London] 281 Unknown Detainee 2: Yo, yo , yo. Leave him man. [Inaudible what the fuck man 288 Unknown Detainee 2: So don't grab him like that, don't grab his head man. What did 289 he do?." (TRN0000089, KENCOV1031, V2017060600011 clip 1)

There is no evidence that the force was excessive and the opinion of others may be attributed to the fact that they are unaware of training and the correct ratio of staff required for a restraint. My opinion that the force was *"low level techniques and head support"* is correct- guiding holds and head support. Witness comment- "279 [Shane Farrell grabs D1538's head and pushes it down while he is still being restrained by Ryan Bromley and Nick London]. There is no set order in which part of the person is controlled and on many occasions the head support is the last to be controlled due to the greater risk coming from the arms. On other occasions the head is controlled first, the dynamic and unpredictable range of incidents cannot dictate the exact order of controlling techniques.

;

ii. DCO Ryan Bromley later speaking to DCO Tulley about Farrell's head grab: "he took his head clean off…they pulled him – pulled his neck right down. That's why even D197's mates were like [inaudible] but hey're the ones that fight him." (KENCOV1033, V201706100007);

iii. Callum Tulley:
(i) during a BBC video diary: "I felt, when Shane came in and grabbed his head, that it didn't seem proportionate to the risk and was unnecessary… The second attempt did seem to be a bit more heavy-handed, let's say. And perhaps Ryan was referring to that head grab. And obviously he had, Shane had, a manager pushing him into the detainee at the time and so it probably didn't help the situation. But clearly, you know, it's not just me that thinks Shane was harsh in the restraint. Ryan feels that way as well." (TRN0000066, BBC000624, KENCOV3052);

(ii) In a "written statement from camera" he records D1538 as "angry but not threatening…Manager Shane Farrell came in and totally needlessly yanked his head which inflamed the situation" (CPS000048)

I cannot comment on individual staff's perception of the incident. If they held such strong opinions I would have expected them to report it or address it with DCM Farrell. My observation on the practical application of the technique is that it was delivered as taught in training and efforts were made to remove it but a decision then made to re-apply.

UOF Incident log 136/17 — D1538
Detainee concerned: D1538
Date of incident: 3rd June 2017
Reason for force as listed on the UOF report: Protect yourself and protect a third party
Staff involved: DCO Fiddy

1. In respect of the above incident, Mr Collier should be provided with D1538's witness statement. D1538's account was that he was provoked and racist language used against him Does Mr Collier agree that the lack of audio means that we cannot actually determine what was said between D1538 and DCOs Fiddy and Instone-Brewer and that there is a clear factual dispute that Mr Collier cannot in fact determine

I could only comment on the evidence provided at the time. It is fact that no audio was available and therefore I could not determine the conversation between D1538 and the two members of staff. My findings and opinion are based solely on the footage and UOF documents.

Annex 4 – Incidents relating to D149

UOF incident log 135/17 — D149
Detainee concerned: D149
Date of incident: 31st May 2017
Reason for force as listed on the UOF report: maintain Good Order and Discipline, noncompliance, refusing to relocate to CSU
Staff involved: DCM Loughton, DCOs Webb, Edon, Tait & Freeburn

We request that Mr Collier is provided with D149's Rule 40 paperwork for this incident (CJS001820)

1. At paragraph 56 of his report, Mr Collier states that "there was justification for locating him in the CSU following his attempt to take a member of staff's keys off them". We have set out our concerns in Annex 1 (D1527) as to these kind of judgments. However, given his view that the Rule 40 decision was justified, we ask him to clarify this by considering the following:

a. The Rule 40 decision states that removal from association was authorised by DCM Pearson at "21:52" on "31/5/17" (CJS001820_0002) which the manager claims to be when he was located into Rule 40 accommodation (DJS001820_0001). The rule 40 decision confirms the Home Office, IMB, healthcare and religious affairs were not informed until 23:00.

b. However DCM Steve Loughton in his use of force report confirms that he was informed: "At approximately half past two on the afternoon of 31st May 2017 I was informed by Duty Director of the day Caz Dance-Jones that she had received a report that a detainee by the name of D149... had attempted to grab an officers keys in the library and that he has done this before in a previous centre so for the safety and security of the centre he is to be moved to our care and separation unit and be placed onto Rule 40." (CJS005650_0008). He then goes on to state that the planned control and restraint to transfer D149 to CSU occurred around 17:19. Written observations from the Rule 40 paperwork confirm that D149 arrived in CSU at 17:30 (CJS001820_0016). The timings of when Rule 40 was actually authorised in writing (22:52) and when he was transferred to the CSU by force (17:30) do not match up. The security incident said to justify an 'urgent' Rule 40 occurred at least three hours before he was moved to CSU. Does Mr Collier agree that:

i. There are clear discrepancies in the paperwork;

A. I did not review any of the documentation for any removal under DCR. I listed the reasons provided on the UOF report as the relevant DCR applying to the specific incident.

ii. The actual written authorisation for D149's removal from association occurred at 22:52, almost 5.5 hours after he was placed in CSU – thus there was no written and lawful authorisation for the initial 5.5 hours in segregation, in breach of Rule 40(1), (5) and (6);

iii. Rule 40(2) was breached – this was not a case of 'urgency' permitting a G4S manager to authorise Rule 40. If it was urgent, D149 would have been taken immediately after the incident was reported. At least three hours passed between D149 arriving in CSU and G4S (at least verbally) deciding he should be placed in the CSU. Home Office authority could and should have been sought. The Home Office were not notified of the decision until 23:00 which is not in accordance with Rule 40(2)

iv. Rule 40(5) was breached in that there was a delay in informing the visiting committee, the medical practitioner and the manager of religious affairs

c. On what basis could removal from association have resolved the safety and security risk said to exist for D149? It appears it was feared he may be an escape risk and attempt to steal a key again presumably at some point in the future, but how could temporary segregation deal with that?

I can base my opinion on my experience working in custodial settings for nearly thirty years. Due to not having the documents for a removal I could not consider the authority to remove a detainee. My expertise for the Inquiry centres around the actual UOF, technical and policy compliant, during the incident rather than the lawfulness and procedural compliance for removal. By placing a detainee in the CSU it would reduce the potential security risk that taking keys from staff presented. In any circumstance when a set of keys are known to have been in a detained persons possession a full key compromise contingency plan must be activated. This can lead to a full investigation of the events and the potential consequences of a key compromise. The worst-case scenarios include- keys being used to facilitate an escape, being use for an act of concerted indiscipline (as at HMP Birmingham in 2016) or the requirement for all locks to be changed. The temporary segregation would allow an initial investigation to take place and for the Home Office to decide on the next course of action.

2. Given Mr Collier's findings at paragraph 64-69, we would be grateful if he could provide greater detail the risks of serious physical injury to D149 given the way in which officers misapplied use of force techniques against him

The training given to staff for moving up/down stairs highlights the dangers that this move presents, this includes trips, slips, fall, all which could result in the staff and the detainee being seriously injured. Staff should have set up the stairway negotiation formation prior to moving. This would require additional staff to act as 'anchors' at the lower side of the three-officer team. Potential injuries would be those consistent with falling down stairs and those resulting from another person falling on the staff/detainee.

The delay in removing the handcuffs whilst D149 was in the prone position at the end of a lengthy relocation would heighten the risks associated with protracted restraint. The incorrect initial positioning of the handcuffs contributed to the problems and should have been addressed earlier during the restraint. Risks from prolonged prone restraint are covered in the UOF training Manual and the medical DVD.

The risks from misapplication of the leg control (known as figure four) would range from discomfort to potential knee or hip injuries. These would be more likely due to the detainee still being restrained on his arms/head, and therefore unable to adjust his body to compensate for the discomfort caused by the wrong movement into the leg restraint.

3. At paragraph 69, Mr Collier concludes that: "It was a necessary UOF to carry out a full relocation when considered against the threats presented by D149. If applied correctly it would have been proportionate but unfortunately the member of staff could not perform it as per the training received. Therefore it did increase a risk to D149 through incompetence rather than by being disproportionate." – Please can Mr Collier clarify this finding on the proportionality of the force used? It appears to be contradictory

My conclusion is that that a full relocation was necessary under the circumstances and that the force used, including the relocation process, was proportionate. I accept that due to the risk of injury by misapplication of techniques it could be considered to be disproportionate. I based my findings/opinions on the process compliance and level of force used, which was proportionate. It was the actual application on the occasions listed that were not performed correctly, and in my view down solely to incompetence by the individual member of staff.

UOF Incident log 157/17 — D149
Detainee concerned: D149
Date of incident: 19' June 2017
Reason for force as listed on the UOF report: Failure to comply with removal, noncompliance, prevent self-harm, prevent injury to third person
Staff involved: DCOs Williams & Brewster, DCM Aldis

1. At paragraph 532, Mr Collier states in respect of the planned control and restraint that "there is no evidence of any prior conversation with him or that he was refusing to move, self-harm or pose a risk to others. I am confused at the reasons for force listed." However at paragraph 535, he goes on to state that the use of force was "necessary and reasonable in the circumstances". However please can Mr Collier clarify how this force could be deemed necessary and reasonable when it plainly does not meet the 'last resort' test? As he says, there is no evidence of prior conversations to ask him to walk compliantly.

My comment relates to the reasons listed for using force did not replicate the description of the incident. There was no information to support the reason of- failure to comply with removal or non-compliance. The reasons for restraint should have been to facilitate a move from the establishment and the use of handcuffs due to the potential risk that D149 presented based on previous incidents of a security related matter. What I found to be necessary and reasonable was the application of handcuffs on a person who was compliant. Under normal circumstances I would question the justification if compliant, but due to previous incidents and security risks I believe using handcuffs to facilitate a move through the centre

Statement of Truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

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

Signed: …Signature…… Dated: …3rd March 2022……..

Jonathan Collier