Second 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

SECOND SUPPLEMENTARY REPORT OF MR. JONATHAN COLLIER– 17th MARCH 2022

Brook House Inquiry

Contents

Introduction

1. This is my second Supplementary report and should be read in conjunction with my first two reports provided to the Brook House Inquiry, dated 14th January 2022[1] and 2nd March 2022.[2] This report has been produced to consider and comment on the additional footage that the Inquiry has received since the completion of my first and second report.

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

[2] [INQ000158] Mr. Jonathan Collier, Expert (First Supplementary) Report on Use of Force incidents at Brook House Removal Centre between 1 April 2017 and 31 August 2017 dated 2 March 2022.

Incident 134/17 involving D1914 on 27th May 2017[3]

Footage[4]

2. The CCTV footage from the landing shows three DCMs and two three officer teams in full PPE approach the room. At 01:39, the door is opened and almost instantaneously, the staff enter. No time was given at the door for any sign of compliance or did any meaningful negotiation take place. This would not support that all reasonable efforts had been made before staff used force.

3. At 01:39, the roommate leaves the room and is taken to another room on the landing. At 08:36, a member of healthcare enters the room with their equipment backpack. I see no reason why the staff stood outside are still wearing helmets at this stage. The incident was under control and the perceived risk now mitigated by staff attendance and the observation of D1914. A mobility chair is seen by the door but is later taken away.

4. At 12:31, D1914 is seen being removed from the room whilst handcuffed and dressed only in a pair of shorts. My expectation would have been to allow him a tee shirt or similar upper body garment as a matter of decency. Watching the evidence from the CCTV enhances my opinion that handcuffs were not necessary and that staff should have at least removed their helmets prior to moving through the centre. Paragraphs 101, 104,105 & 115 and 120-122 from my first report. The relocation that moves through the corridor and into E Wing where D1914 is located in a room at 14:55. At 20:30, the staff exit and the room door secured. A constant watch is positioned outside of the room.

5. My findings on this incident have been strengthened by the footage and all of my opinions remain as described in paragraphs 120-124 of my first report. This incident can be aligned to para 636 of my first report, namely removing PPE once the risk has been reduced and allowing the detainee a period to reflect and consider what staff have instructed them to do.

Incident 86/17 involving D2159 on 5th April 2017[5]

Footage[6]

S1970001- Briefing

6. The briefing was carried out by DCM Dix and states healthcare had serious concerns and that D2159 had serious medical conditions. There had been attempts to persuade D2159 to move but when the briefing was given, DCM Dix described it as not 'peacefully'. There was no

[3] [INQ000111] Mr. Jonathan Collier, 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.
[4] 230517 - BH 272-17, UOF 134-17, DVT 207-17;
[5] [INQ000111] Mr. Jonathan Collier, 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 125-133
[6] S1970003.MP4; S1970001.MP4; S1970002.MP4

information on why it would not be peaceful and the use of this language could present a different picture to staff. This is not the same as non-compliance, which can come in many forms including passive resistance.

7. I did not observe anything from the briefing that justified force being a planned consideration apart from previous assaults on other detainees. I also question why it was felt handcuffs should be used. If staff had engaged with D2159 they would have observed his demeanour and assessed the threat he possessed at the time, notably after several days of food refusal.

8. Healthcare confirmed their concerns during the briefing and advised staff on using force when considering the condition of D2159.

S1970002

9. DCM Dix looks through the observation panel and informs the team that D2159 is on the bed. He then opened the door and allowed the team to enter, in full PPE with a shield, before attempting to engage with D2159. This is not good practice and should not have taken place. After observing D2159 on the bed, DCM Dix could have entered with the team in close attendance if required.

10. The shield is then gently placed on D2159 for a short period after he does not respond to DCM Dix. Although only a minimal contact is made, I see no reason why it was even used when based on the threat level offered from D2159 on the footage. After an attempt to move D2159, it is decided that handcuffs be applied. From the footage, there is no clear risk presented and D2159 appears weak and unable to walk. At this point I would have expected consideration for alternate methods of moving D2159, including a mobility chair which is seen to be available outside of the room. Once handcuffs are applied, the staff in PPE should have removed some items (helmets in particular).

11. At 09:09 into the footage, D2159 drops down and is offered the use of the chair but decides to walk the remainder of the route into E wing. D2159 is located into a room on E wing before any medical checks are carried out and when the door is secured, he is observed sitting on the bed.

12. At paragraph 131 of my report, I noted that D2159 was offered medical support but refused. Based on the footage he did not refuse, he simply did not answer.

13. My initial opinion of this incident remains and is supported from the footage which gives clear evidence of the risk and threat offered at the time. If earlier attempts to persuade D2159 had been attempted by the DCM I feel that this is an area where more effective use of BWVC should be Introduced. The recording of any communication regarding a removal should be included within local protocols for automatic activation of a BWVC, Recommendation 5.

Incident 137/17 involving D390 on 5th June 2017[7]

Footage[8]

14. The additional footage covers a very quick debrief of the staff involved by asking if they had any injuries to report. All confirmed no injuries.

15. If this was the extent of the debrief then it was not to the standard expected and did not address wider issues or any concerns from the staff, or any feedback from the DCM on their performance- good or bad.

16. This emphasises the need for a bespoke package for the DCM group, recommendation 1, on managing incidents, including how to conduct a debrief, what it is set out to achieve and how to take any learning from it. An effective debrief not only covers welfare issues but training needs and learning.

17. Nothing within the evidence to alter my opinion of this incident at paragraphs 243-264.

Incident 114/17 involving D1527 on 4th May 2017[9]

Footage[10]

Footage from BWC A & B .mp4

18. Footage shows the movement down the stairs through to the relocation on E wing. DCM Dix does take over control of the right arm from DCO Yates, whom D1527, from my first report, appeared to have a problem with.

19. No changes to my initial opinion of this incident.

Incident 129/17 involving D52 on 22nd April 2017[11]

Footage[12]

20. I can confirm that due to the evidence now presented my opinion from my first report, paragraphs 351-371, and specifically paragraphs 367 & 368, has now changed. No footage was available when I made my conclusion for this incident. The new footage clearly shows that at

[7] [INQ000111] Mr. Jonathan Collier, 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 243-264.
[8] UOF 137.17 BWC.MOV
[9] [INQ000111] Mr. Jonathan Collier, 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.
[10] UOF 114.17 BWC A.MOV;
[11] [INQ000111] Mr. Jonathan Collier, 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 351-371.
[12] UOF 129.17 BWC.MOV

the point (07:03) force was initiated it was not the last resort and the UOF was not necessary at the time.

21. The relevant footage begins at 0:46 when D52 is called into a room by the DCM and they sit down and engage in a conversation regarding the removal order issued earlier that day. Two other staff are seen in the room, along with one outside and the camera operator. There is no mention of who was recording the incident. D52 was quoting some technicalities over the removal order and that he needed to speak to his solicitor. The DCM explained that he was to be moved to E wing as the Home Office had reported he told them he would fight staff. D52 was told that once in E wing he could have access to the phone and carry out all of his tasks.

22. D52 stated that he wanted to go back to C wing and pack his personal items but the DCM informed him that staff would do it for him and bring them down to E wing. This agitated D52 and he began to get more vocal and thumped down on the table. At 07:03, force was initiated by staff but no instruction was given by the senior person (DCM) in charge at the time. D52 then starts to scream and the camera moves away from the incident and does not capture any footage from the restraint as a hand appears in front of the camera. I would question why the restraint was not recorded when previously everything was recorded.

23. The instructions to D52 and the communication are heard and the bite to DCO Marshall's back is mentioned. At 08:45 the camera starts to record the restraint when D52 is on the floor and handcuffs are then applied. At 10:16, it appears that a DCO is trying to cover the camera again with their hand. D52 is stood up and a female in civilian clothes and a member of healthcare are seen. At 11:05, a conversation takes place about changing over the camera operator. D52 is then relocated to E wing whilst stood up with his arms supported.

24. When force is initiated, it was not when all reasonable efforts had been made and there was no reason for force at that stage. D52 was agitated but at no time did he offer a threat towards the staff or did he indicate he would not move provided they reached an agreement he could go and collect his belongings. More effort should have been made to for a resolution and if necessary allow D52 time to consider the Instructions. Due to the time of day, there was no urgency to move him and in situations of this nature, prolonged negotiation should be the resolution strategy. At no time did D52 offer any violence to staff or was there any sign of staff being at risk of harm. The period of discussion is approximately 6mins 30 secs, due to the circumstances I would have expected a longer period to try to find a mutually amicable solution to the issues raised by D52.

25. In paragraph 359 of my first report I gave my opinion that this was in fact a planned incident and the evidence from this footage strengthens my opinion. The DCM should have informed the DD and whilst negotiations were ongoing, he should have then planned for using force if all other efforts were unsuccessful.

26. It is unclear who is operating the camera and I am deeply concerned that the initial restraint was not recorded when previously it recorded the conversations, and afterwards it recorded the handcuffing and transfer to E wing. The hands over the lens could have been accidental

but is unclear who is actually operating the camera. The following conversation confirms the presence of a camera but during my first review, no footage was available. The witnesses to the incident did not complete statements as per the G4S protocol.

27. My opinion is now that this was an unnecessary UOF and I could not evaluate the force used until D52 was under control just prior to handcuffs being applied. This differs to my opinion on other incidents when a detainee refused to move due to the fact D52 was not being handed over to the overseas contractor escort staff until the next day, whereas in other incidents the escort staff were waiting and had to meet the deadline of the charter/scheduled flight.

    Additional footage from CCTV listed as 220517- BH 268-17.13

28. At 08:00, attention is drawn to the interview room as staff from other rooms come out and go to the room. At 08:55, DCO Marshall exits the room and is seen by a colleague who checks the area of the bite. They then both leave the area. At 10:17 healthcare arrives on scene. At 11:20, D52 is being escorted by staff from the interview room.

29. D52 is moved down the stairs and through the corridors onto E wing. This is being recorded on a BWVC by a male in civilian clothes. He hands the BWVC over to a DCO once D52 is relocated in the room. At 18:36, staff return with healthcare and they re-enter the room. At 20:36, all staff leave the room and a constant watch is observed with one DCO outside the room.

30. No evidence to change any of my previous opinions or findings. I would question why the BWVC issues I have observed had not been identified during any review of the incident and investigated.

Incident 133/17 involving D1978 on 23rd May 2017[14]

Footage [15]

31. The footage starts with D1978 and a female member of staff coming through different doors and meeting on the landing. They are in close proximity to each other, D1978 takes some small steps toward the member of staff, and his arms move to the side in an exaggerated gesture. The conversation attracts the attention of other detainees who are sat at a table. During the coming together, the member of staff uses a push to create distance and the conversation continues with D1978 still close to her. She then opens a door and additional staff then arrive on the scene- end of footage.

32. It is my opinion that the use of force demonstrated was necessary at the time in order to create distance and was proportionate to the threat posed by D1978. Without the benefit of

[13] 220517 - BH 268-17, UOF 129-17, DVT 203-17.mp4
[14] [INQ000111] Mr. Jonathan Collier, 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 372-402.
[15] 230517 – BH 271-17, UOF 133-17, DVT 206-17.mp4

any audio I am unable to comment on the conversation or the tone/language used. Effective communication should be at a socially accepted distance, for instance not up close and almost face to face. There was obviously something said that made the other detainees turn around and see what was happening.

33. This does not alter my findings from this incident paragraph 372-402. It does however support the comments and reasoning for removing D1978 due to his behaviour and attitude toward staff.

Incident 88/17 involving D2416 on 11th April 2017[16]

Footage[17]

Footage from BWC. mp4

34. The DCM enters the room and informs D2416 of the removal. When D2416 refuses, a short explanation takes place before the team are deployed. The timeline from starting the conversation to the team applying force is 00:13 to 00:39, approx. 26 seconds. This is not sufficient time to explain and try persuasion for compliance. My opinion on this being the last resort (paragraph 425) has now changed due to the limited attempts made by the DCM.

35. I question why the DCM insisted for the head support to be applied for moving down the stairs when D2416 was compliant, although he was verbally challenging but not offering a threat or risk at the time. There is nothing to support the comment in paragraph 422 that D2416 was trying to use his feet on the railings to disrupt the movement at this stage and D2416 only attempted this when on the stairs (not seen on footage due to decency but referenced momentarily at 07:27).

36. It appears from the footage that D2416 is taken to the bottom of the stairs and that Tascor staff are there for the escort. D2416 is left naked in the presence of at least seven staff from 08:50-17:35. This appears to be whilst a sheet is being found to cover him; if this is correct, I find it unacceptable and degrading. There was ample opportunity to arrange for clothing to be made available beforehand and for only the necessary staff to be present whilst D2416 was undressed.

[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, paragraphs 421-429.
[17] UOF 88.17 BWC.MOV

Incident 153/17 involving D1853 on 15th June 2017[18]

BWVC footage from CAM.MP4[19]

37. The incident starts with staff entering room A105 occupied by two detainees, one being D1853. DCM Lyden explains that D1853 is to be moved and his clothing is checked before being allowed to dress himself. He then walks out of the room and down the landing.

38. D1853 is unhappy with the situation and enquires about his personal possessions. He is repeatedly told that they will follow once he in the discharge area.

39. Once the staff reach the end of the landing, D1853 moves away and is effectively cornered. He then refuses to move (04:04 on the footage) and after a short period, (04:20 on the footage) force is initiated after an Instruction by DCM Lyden. At paragraph 431 of my first report, I noted that DCO Moshiri stated D1853 ran down the landing and he gained a headlock. There is no evidence that D1853 ran down the landing, he simply moved away from the shields toward the corner of the landing. At paragraph 434 DCM Lyden mentions concerns over the possibility of D1853 accessing the netting. This is not evident from the footage and with at least six staff in attendance, any attempt to access the netting would be difficult. If DCM Lyden was that concerned, he could have applied handcuffs to D1853 in the room prior to moving.

40. My view on whether force was the last resort, paragraph 442, has now changed due to the fact force was initiated after approximately 16 seconds when D1853 stopped moving. More time should have been given to explaining the situation and reassuring him that his possessions would be packed and follow him down to the discharge area. Despite some gesturing this was no imminent risk of harm and more persuasion should have been used. When force is used, the handcuffs should have been applied but DCM Lyden decides against it after D1853 states he will walk off the wing.

41. The issue of a PIT is difficult to establish. The wrist of D1853 is flexed but there is no indication of the wrist being flexed to cause pain. D1853 does mention that he wants the left wrist to be eased off and at one point, this does happen and is clear from the footage at 08:18, but is then flexed again. At no time did any staff give an instruction to D1853 or follow the protocol before applying a PIT, or did I see anything that warranted the use of a PIT.

42. At 07:40 D1853 headbutts DCO Harkness but for some reason DCM Lyden did not include this within his report despite clearly seeing the incident and raising his voice when instructing D1853 to comply.

43. The opinion at paragraph 443 & 444 remains although it is impossible to clarify if PIT were used. D1853 complains of pain but does not react in a manner consistent with the application of a PIT.

[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, paragraphs 430-446.
[19] UOF 153.17 CAM.MP4

44. The two additional footage from MP4 and (2) MP4 is the briefing and debriefing of staff. One note is that Healthcare were in attendance both at the briefing and through the incident. BWC.mp4 is the same footage as CAM.MP4 but from a different angle.

Incident 104/17 involving D1527 on 24th April 2017[20]

Footage[21]

45. The footage is from CCTV outside of the room only. Initially a DCO attends and looks into the room (0:25) and then enters. A female in civilian clothing stands outside and at 0:57 she leaves and a DCM (white shirt with BWVC lanyard) and two further staff attend and enter the room. At 1:48, two staff leave the room and by 2:34, all staff have left with the DCM stood at the door whilst it is still unlocked.

46. In my report paragraphs, 518-524 I give my reasons why force was necessary following an act of self-harm based on the information provided by the statements of staff. There is no further evidence to alter my initial view. I am concerned that the BWVC was not activated, although from the camera footage it is not 100% clear the BWVC was actually attached to the lanyard.

Incident 157/17 involving D149 on 19th June 2017[22]

Footage[23]

S2210001- Briefing

47. No issues

Footage from BWC. Mp4 and S2210002-

48. D149 is removed compliantly from his room and escorted to another area where he is handed over to Tascor staff. Handcuffs were applied initially and then transferred into the WRB.

49. No change to my initial opinion of this incident.

[20] [INQ000111] Mr. Jonathan Collier, 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.
[21] 240417 - BH 179-17, UOF 104-17, DVT 149-17
[22] [INQ000111] Mr. Jonathan Collier, 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 531-535.
[23] UOF 157.17 BWC.MOV; S221001.MP4; S221002.MP4

Incident 110/17 involving D2559 on 28th April 2017[24]

Footage[25]

50. The footage shows Mr Paschali arrive on the unit, which appeared to be in patrol state as no detainees or staff were present and go straight to the room and enter (at 0:51 into the footage).

51. At 1:30 Mr Paschali is seen at the door looking as though he was about to exit but then re-entered out of view of the camera. He finally left the room at 1:46 and secured the door.

52. The entry into the room varies from the description in Mr Paschalis's statement that the door was difficult to open. The footage shows he had no issue opening the door and went straight into the room. I also observed that Mr Paschali did not appear to open the observation panel in order to evaluate what was happening in the room. It is standard practice for staff to check in any room before entering. If as described, D2559 was making a noise I would expect some dialogue at the door before going in, especially if the member of staff is isolated.

53. I was unable to give an opinion within my initial report of this incident and the lack of any evidence from within the room does not assist in forming a judgement. I am concerned that the statement varies from the actual incident and that basic procedures were not carried out, for example; observing through the panel, engage from outside, going into the room with no others present.

54. My initial report remains (paragraphs 553-557) but with added concerns now over the events.

Incident 108/17 involving D1199 on 24th April 2017[26]

Footage[27]

55. The footage shows a DCM at the door who after a short discussion moves aside and gestures for the team in PPE to enter the room at 00:36. At 00:54, the team exit the room with D1199 being held in low level restraints techniques involving one member of staff on each and arm and with D1199 allowed to stand upright. The incident is being recorded with a BWVC and healthcare are in attendance.

56. At 01:22, D1199 is relocated into another room with staff going in to carry out a search prior to escort. Within the unit are four staff from the escort provider who are waiting for him to be handed over to them. D1199 leaves the room at 08:14 and is then seen engaging with the escort staff. This carries until 14:35 when they all leave the area.

[24] [INQ000111] Mr. Jonathan Collier, 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.
[25] 280417 - BH 204-17, UOF 110-17, DVT 166-17.mp4
[26] [INQ000111] Mr. Jonathan Collier, 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 565-572.
[27] S2010001.MP4; S2010002.MP4; S2010003.MP4; 260417 - BH 183-17, UOF 108-17, DVT 153-17.mp4

57. In paragraph 568 of my report I note that the healthcare section of the UOF document had not been completed. All detainees should be seen after any UOF and prior to transfer. No F213 was presented within the documents for review.

58. My conclusions from my first report, paragraphs 565-572 remain that force was necessary due to removal order and that it was the proportionate amount in the circumstances.

Incident 108/17 involving D1199 on 24th April 2017[28]

S2010001- Briefing

S2010002

59. This footage is from the intervention by staff. DCM Roffey opens the room door and asks D1199 to stand up, which he does. For some reason DCM Roffey then send the staff, in full PPE with a shield, into the room. The shield makes light contact and is quickly removed once it becomes clear D1199 is not offering any resistance or threat to staff. UOF techniques are applied on the instruction of DCM Roffey but the head support is not applied.

60. My concerns are why did DCM Roffey send the team in and why did he tell staff to apply ' locks'?

61. My opinion, paragraphs 569 & 572 from my first report, has now changed and that based on the new evidence force was not the last resort or justified as D1199 was complying with the Instructions and not offering any threat or risk. I see no justifiable reason for the restraints to be continually applied until moving into the room for a search.

62. The footage then covers the handover to Tascor staff.

S2010003 – Debrief

63. DCM Roffey is incorrect in stating staff used guiding holds; the staff are clearly seen using a C&R technique known as final lock. He also sated D1199 did not comply straight away; I again challenge this as the footage is clear that D1199 stands up when told.

Incident 97/17 involving D2636 on 21st April 2017[29]

Footage[30]

64. The footage begins with a solitary DCO (blue polo shirt) outside of the room until two DCM's (white shirts with BWVC lanyards on) arrive and enter the room at 0:49. The DCO then leaves and goes out of view. At 1:45, the DCO runs from across the unit into the room. At 2:23, all three exit the room, with the DCO adjusting his shirt.

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[28] [INQ000111] Mr. Jonathan Collier, 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 565-572.
[29] [INQ000111] Mr. Jonathan Collier, 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 graphs 573-580
[30] 2104 - BH 170-17, UOF 97-17, DVT 141-17. mp4

65. Further to my initial report, paragraphs 573-580, I now have concerns over the reporting of this incident. The DCO was involved and did enter the room. Based on the information I have now that was not presented during my initial observations the G4S policy stated that any witnesses to an incident should submit a statement. This has not been provided as evidence so far. In paragraph 578 I questioned why BWVC had not been activated by the two DCMs in light of the reasons for removal to the CSU. This evidence clearly shows them to be in possession of BWVCs.

66. There is a failing in two local procedures – BWVC & witness statement.

67. Due to the lack of evidence from inside the room, I am unable to further review my initial findings and my opinion remains, but with concerns over how many staff were actually involved in the UOF. The DCO emerges from the room after 38 seconds (approx.) therefore; he would have either seen or become involved in the UOF without making a statement.

Incident 98/17 involving D2636 on 21st April 2017[31]

Footage from BWC A & B.mp4 [32]

68. The footage starts in a corridor with a detainee in the supine position. Staff are securing his head and arms but the detainee is screaming as though in pain. The holds used initially do not appear to be those, which could cause pain, and the leg restraint is removed then re-applied prior to sitting up the detainee. The techniques used for sitting are not correct for the supine position and should have been identified by one of the several DCM grades in attendance.

69. No change to my initial opinion of this incident.

Incident 98/17 involving D2636 on 21st April 2017[33]

70. The footage starts at 01:14 when a DCO unlocks a door from the corridor and D2636 drops a pool cue and then move toward the DCO with a broken pool cue in his hands. He then proceeds to follow the DCO along the corridor until another door opens and other staff appear. D2636 then moves and confronts them and throws one half of the broken pool cue and then drops the other half. D2636 is initially surrounded by five DCOs then a DCM appears and moves toward the situation. Two more DCMs and two DCOs then arrive at the scene, followed by multiple other staff including healthcare.

71. In paragraph 538 of my first report I reference the initial attack on DCO Clarke (the DCO on the footage) and this is seen at 01:20 of the evidence as can the throwing half a pool cue at staff who have arrived.

[31] [INQ000111] Mr. Jonathan Collier, 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 581-587.
[32] UOF 98.17 BWC A.MOV; UOF 98.17 BWC A.MOV
[33] [INQ000111] Mr. Jonathan Collier, 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 581-587.

72. There is no BWVC evidence available despite observing five DCMs on scene and the UOF statements saying they were used.

73. At 02:24 in the footage, staff restrain D2636. The reasons listed from the statements, covered in paragraph 581 of my first report, were the refusal to take his hands from his pockets and attempts to strike staff. Due to the slight time delay in the footage, it is unclear on the attempted strike but an action was observed by D2636 toward a DCO.

74. The restraint ended up on the ground and from what I could observe all techniques appeared to be consistent with training and where reasonable for controlling a detainee on the ground. At 04:20, D2636 is stood up and at 04:47 the head support position is removed and D2636 is then walked to the CSU with no issues and relocated.

75. As per the G4S procedure at the time all witnesses should have completed a statement, none have been presented as evidence or has any BWVC evidence.

76. My original opinion of this incident remains, paragraphs 582 and 587, with the additional footage confirming the information provided within the UOF statements

Incident 112/17 involving D68 on 29th April 2017[34]

Footage[35]

77. The footage shows a detainee who I assume to be D68 engaging with staff at the far end of the unit. Nothing appears to be an issue as others, including a second detainee who later comes into view and DCO Sayers (who I recognise from previous footage when he gave his name during an incident debrief.

78. The situation changes and DCO Sawyers moves between the DCO and D68. The footage then shows a reaction from D68 that is consistent with being pushed. The second detainee comes from a room and steps in between the staff and D68, he was obviously reacting to something he heard that alerted him and made him come out of the room.

79. With no audio available for me to re-assess my initial report I remain with my initial opinion (paragraphs 620-624) that the push was necessary to move D68 from DCO Sawyers' personal space and that the force used was proportionate to the circumstance at the time and only after other methods were not successful. I base this on the probability between the coming together and when the push was delivered, which was enough time to issue instructions to move.

[34] [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 620-624.
[35] 290617 - BH 206-17 UOF 112-17, DVT 168-17.mp4

Incident 145[36]

Footage from BWC. mp4

80. A restraint on the floor involving an eastern European male who communicates with a DCO in another language. Handcuffs are applied for a walk of a few metres.

81. Nothing of concern over this incident.

Conclusions

82. Based on the additional evidence that I have now been provided I have identified a number of incidents where the interaction between the DCM and detainee was not sufficient and does not evidence that all reasonable efforts had been explored in order to gain compliance. This is essential when justifying force was used as the last resort and that other methods had been tried without success.

83. The incidents are-86/17, 88/17,108/17, 129/17,153/17

    The timelines between giving an instruction and initiating force are not sufficient for the detainee to process the instruction and do not give justifiable reason for making the assumption of non-compliance. These failings would have been identified during a UOF Committee meeting, recommendation 3, and the DCMs should be asked to explain why force was used so rapidly and the lack of information within their UOF report relating to the engagement with the detainee.

84. Within recommendation 7 of my first report I highlight the necessity for UOF reports to be scrutinised by managers. Several of the initial reports I read do not accurately reflect the additional footage now available, for instance-110/17- DCO Paschali indicated difficulty opening a cell door but the footage indicates otherwise, also why DCO Paschali entered the room without checking first or summoning others. This is a management failing and does not provide reassurances that incidents involving force are being correctly recorded, which in turn brings into question the legality for using force.

85. BWVC usage has been identified, recommendation 5, as being inadequate. Paras 22-23 of this report identify another serious area of concern. The BWVC moves from the time force is initiated and only focuses on the incident once control is gained. Further attempts to cover the lens are seen later during the incident. This action left a 'gap' in the evidence at a crucial stage when force was being used. This is also a failure when considering a member of staff was bitten during the incident.

86. During incident 97/17 staff are seen at the scene but they did not complete a witness statement as outlined in the G4S policy. This should be managed as a performance matter, along with failure to activate BWVC, after any formal review of the incident.

[36] Incident not listed within my first report. UOF 145.17 BWC.MOV

87. The post-incident debrief of staff is another area that needs to be a standardised. The content of the debrief should cover wider issues other than the usual 'any injuries'. Valuable lessons learnt and improvement plans can be initiated form a debrief and staff should be able to raise any concerns resulting from the event. I did not observe any mention of the staff aftercare services available. This is an important mechanism for staff following difficult and often emotional situations involving detainees in crisis who resort to extreme actions, and on some occasion's colleagues being injured during the incident. The employer has a responsibility to their staff and suitable support services must be available when considering the work environment and the often unpredictable situations that occur.

Statement of Truth

88. 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: ... 17 March 2022.....

Jonathan Collier