BROOK HOUSE INQUIRY

Second Witness Statement of Steven Dix

I, Steven Dix, will say as follows:

I provided a previous witness statement to the Brook House Inquiry following a request under Rule9 of the Inquiry Rules 2006 dated 15 June 2021.

In response to a further Rule 9 letter from the Inquiry dated 27 September 2021, I now make this second witness statement to address the particular issues identified within that letter. I will respond to each of the Inquiry's questions in turn, adopting a suitable subheading to divide the questions. The below statement is accurate and true to the best of my knowledge and memory of the period 1 April – 31 August 2017 (the 'Relevant Period'). Since my first witness statement was provided, I have now had the opportunity to review additional documentation that relates to the Relevant Period to assist me in providing further details. The documents I have been asked to consider are referenced within this statement.

Use of Force ("UOF") against D1234 on 28 March 2017

1. I have had an opportunity to review documents HOM003438, HOM002497, HOM002485, HOM002750, HOM002495 and HOM002496 referred to by the Inquiry. These documents pertain to an incident involving a Use of Force ('UOF') against D1234. Specifically, D1234 was being removed from his room to be escorted to a chartered flight.

2. The documents provided indicate that I prepared a UOF report and an incident report following the incident, which is standard procedure.

Steven Dix

Signature

3/2/22

3. Based upon my recollection of procedures in place during the Relevant Period, where there was a concern regarding non-compliance, the normal process for a planned removal would be as follows. In the first instance you would enter into negotiations with the resident prior to the removal, to ask whether they were willing to leave their room safely and of their own accord. You would also speak to a senior manager to make them aware of the situation and inform other parties like healthcare. If a planned removal was still required, a briefing would be held and staff would don suitable personal protective equipment ('PPE'). You would then go to the resident's room and provide them with an opportunity to comply of their own accord depending on the situation and any risks identified. If the situation could not be resolved peacefully, UOF would occur as a last resort.

4. I have had an opportunity to consider the National Tactical Response Group ("**NTRG**") report. At the time it was my belief that it was appropriate to handcuff residents behind their backs whilst seated or standing, if necessary. My knowledge now is very different, as I am now a Control and Restraint ('C&R') instructor. Handcuffs should be applied behind a resident's back in a standing position. Residents are only handcuffed in specific circumstances, for example, to carry them safely following a violent outburst.

5. This incident occurred many years ago. However, from my recollection and the reports I have read, the individual being removed was middle aged and was naked at the time. He was being taken from Brook House to be placed on a deportation flight. Due to his non-compliance with our instructions, it was necessary to use force to facilitate his removal.

6. When a resident is naked during a UOF incident, I would try to ensure that their dignity was preserved. This included, for example, diverting the camera away from the individual to prevent naked images being captured of him. However, this would only occur if it was safe and possible to do so and the camera would be repositioned as soon as possible.

7. I have nothing further to add to the account I provided during an interview on 7 September 2017.

UOF on 25 April 2017

8. I do not recall this UOF incident, but I have been referred to documents CJS005945 and CJS005941 and seen video footage which has assisted by memory slightly. I do not know why I attended Eden wing. I may have been the Oscar 1 that day, or I may have been radioed to attend. If I had been Oscar 1, I would not have been in the role for a significant period of time. By way of background, I joined Brook House in January 2009 as a DCO. In or around 2010, I was promoted to DCM but for my first 6/7 years, I was based on reception where the role is very different to that of a DCM on the wings. In or around 2016/2017, I moved from reception to the wings, so although I had been a manager for a number of years, my practical experience on the wings was more limited.

9. I do not have any recollection of the resident being restrained, but having seen footage from the Panorama programme, I understand that this was the case. From memory, I arrived at the scene after the incident had taken place. Consequently, I had very limited knowledge of what had occurred and who was involved. As someone who worked on the wings of Brook House, I would have attended incidents multiple times per day, so it is difficult to recall the specifics of each interaction, unless they are particularly memorable.

10. I do not recall why I attended room 7 on that particular occasion. It is possible that I was called over the radio to attend, but I cannot confirm with certainty. Similarly, I do not recall what I saw upon entering room 7.

11. I do not recall the details of my conversation with DCO Paschali on the date in question.

12. Similarly, I do not recall the details of my conversation with DCM Giraldo-Albelaez. I assume that upon entering room 7, the resident was in the room, but I do not remember this for certain. If the resident was in the room, it is likely that we tried to engage the resident in conversation to deescalate the matter. Again, I do not recall any of the conversations I had with the individual who had been restrained.

13. Having had the opportunity to review documents and footage related to this matter, I believe that it would be considered a UOF incident. In such cases, a UOF statement, an incident report and an F213 healthcare form would need to be completed. It is important to note that my recollection is that I arrived at the scene after the incident had taken place and therefore, I would have relied on the description of the event provided by those involved. Consequently, if an altercation was not portrayed as a UOF incident, I may not necessarily expect these documents to be completed. I appreciate that in hindsight, this case appears to classify as a UOF and therefore the necessary documents should have been prepared. It would be the responsibility of individual officers to ensure that they completed the correct forms, although managers were often involved in collating such documents. In this case, I can see that another manager was involved, DCM Giraldo-Albelaez, so it is likely that one of us would have been responsible for this collation process. If there are missing documents, I can only assume that officers failed to prepare the necessary reports and that I (or DCM Giraldo-Albelaez) did not chase this up as I was unaware of what had occurred (and that this was a UOF incident).

14. I do not know why I did not record this incident on the constant watch log. In hindsight, knowing what I know now, I should have recorded this. This appears to be a case of human error / oversight. It is also plausible that I may have made a record of the incident, but that this record has been lost or misfiled over the years. I flag this, as there are a number of occasions referred to by the Inquiry where I was surprised to read that a record had not been submitted and there are also some incomplete documents that have been provided.

15. There is a possibility that I may have failed to record incidents on previous occasions, but I am unable to provide specific details. I wish to stress though that I would never fail to record an incident intentionally or maliciously and there was never any form of collusion to not report matters. Ultimately, preparing reports was not a difficult task for me, so the only reason not to record an incident would be due to human error, which might have been caused by, for example, the sheer amount of work / incidents we were required to undertake / respond to.

16. I do not know and am unable to comment on whether other officers failed to record incidents.

17. I do not recall why I did not record my conversation with the detained person or the staff involved. This error would not have been made on purpose and in hindsight, I appreciate that I should have recorded my conversations at the time.

18. As set out above, I do not know whether I or other officers failed to record incidents on other occasions. However, from a personal perspective, I would never have failed to record an incident maliciously or purposefully. The errors that may have occurred in the past are very unlikely to occur now, due to the additional quality control checks in place.

19. Based on the materials provided, it appears that others involved did not record details of this incident. However, I cannot comment on other officers' actions.

20. Based on my recollection of the procedures in place at the time, if a resident had self-harmed after care would be provided by healthcare. This would be documented on an F213 and the resident would have been placed on a supporting document, such as an Assessment Casework Detention Teamwork ("**ACDT**"). Individuals could also be sent to E wing which has large glass panels and no toilet wall to enable easier monitoring and constant supervision.

UOF against D1914 on 27 May 2017

21. I have reviewed documents CJS005981 and CJS005975 in relation to this incident. UOF can be used to facilitate removal directions and this is a common reason for using force, together with UOF to prevent self-harm. When dealing with removal directions, the preference would always be to speak to the resident and use verbal communication to ask them to leave their room of their own accord. However, if they do not wish to leave, UOF is the only feasible option available.

22. I recall that I spoke to D1914 throughout the day in an attempt to get him to comply with the removal peacefully. I believe that I was the residential DOM on that wing and that DCO Sayers had also spoken to D1914. It is likely that we had negotiated with him to encourage him to comply with the deportation order. There may be more information regarding this negotiation in the briefing script for this matter, but I do not have access to this. From memory, I recall that D1914 had heart issues and that I was not keen on conducting a UOF for this reason. I believe that these concerns were passed higher up the chain of command (albeit, I do not know whether I documented this anywhere) and that doctors confirmed D1914 was fit for C&R.

23. I do not recall whether D1914 had a roommate. It is standard practice for 3 or 4 officers (excluding managers, the health care team etc.) to be involved in a planned UOF - one to control the head, two to control the arms and one to control the legs. Notwithstanding this, I would use or take as many officers as I felt necessary (based on the risk assessment performed in advance) to ensure the safety of the resident and my officers. If a resident had a roommate, you would need the same number of officers for that person too. You may also require additional officers if, for example, it was necessary to bring the resident down a flight of stairs. I recall that D1914 was particularly aggressive and a prolific self-harmer.

24. I had not attended an MMPR refresher in the previous 6 months.

25. According to my recollection, MMPR refreshers were offered every 6 months. MMPR training is principally required when working with families, including women and children. Brook House only held men, so it would not have been necessary for me to complete this refresher training. In fact, I do not recall ever receiving MMPR training as it was not applicable to my role.

26. According to my recollection of the policies in place at the time, all planned interventions are filmed to capture the details of the event. This provides safety for residents and staff. It also allows planned interventions to be reviewed at a later date for any learning points.

27. I am not sure what happened to the footage at the time. This was not one of my responsibilities.

28. As detailed above, I recall that D1914 informed me that he had heart issues and had previously undergone operations for these issues.

29. According to my recollection of the policies in place at the time, full searches were necessary when looking for prohibited items, or in order to safeguard the resident, other residents and / or staff.

30. During full searches residents are asked to remove the top half of their clothing first. This is removed and searched and given back to the resident to put on. Alternatively, fresh sterile clothing is provided. Lower clothing items are then removed and searched. When underwear is removed a towel is held up to protect the dignity of the resident. The resident is asked to complete a 360 degree rotation and then clothing can be placed back on. The resident is not touched or asked to squat.

31. An ACDT was opened and he was placed onto constant supervision to safeguard him. From memory, I recall D1914 had a significant history of self-harm and scars on his body where he previously used items to self-harm. I do not know the exact reason why he was placed on constant supervision. This may have been completed

as a precautionary measure to keep him safe. The paramount concern was always to keep residents safe.

32. I do not recall how long D1914 was on constant supervision. The decision to take an individual off constant supervision was usually made by a multi-disciplinary team involving health care, the duty director and other bodies, including the Home Office in certain cases.

Incident on 19 June 2017

33. I have reviewed document CPS000060. I do not recall this incident specifically, or how long it would have taken to move residents to B wing. I do not recall regular complaints about room temperatures, but it was not unusual for individuals to complain about anything they wished to complain about.

34. If a complaint was made about temperature, I expect that facilities management would be contacted and matters would be escalated as necessary.

Incident on 4 May 2017 involving D1527

35. I have reviewed document CJS007209. I do not recall why D1527 jumped onto the netting, but it was quite a regular occurrence at Brook House.

36. From my knowledge, the process to remove a resident from the netting would be to ask them to get off themselves in the first instance. Sometimes this may require a little assistance from staff to help them off the netting. If the resident refused to get off the netting then NTRG, who are specialists in dealing with incidents at height, may be contacted to safely remove the resident.

Questions relating to documents CJS007210 and CJS007215

37. I have reviewed documents CJS007210 and CJS007215 and do not recall why I did not record this conversation. If it was a noteworthy conversation I imagine that I would have recorded details of it. However, if it was just a generic conversation, I might not necessarily record this due to the sheer number of conversations I had per day. Again, I would note that although the Inquiry does not have a copy of a record of this conversation, this does not necessarily mean that I did not produce one. I may have produced one, but it could have been filed incorrectly or lost in an administrative error. Again, these incidents took place many years ago, so it is difficult to remember day to day routine actions.

38. I do not recall why I did not read the Nurse's records at 19:40. It is something that I would do today. In this particular case, I had arrived at the scene after the UOF had taken place. During the relevant period, incidents occurred frequently and my priority was always focused on the individuals involved. This may explain why I did not read the records in full. I do not recall there being a policy in place where we were required to read the records of constant supervision.

39. With regard to this incident, I do not recall any conversations with DCO Paschali, or being informed about the choking incident by either DCO Paschali or the resident. If I had been aware of this, it would have been escalated and the necessary reports would have been filed. Senior managers would then take the next steps.

40. My recollection is that the resident may have had an implement, such as a blade of some description, which he could have used to hurt himself, myself or others.

41. If you think someone is going to grab a weapon and you believe that they could hurt themselves or others, you should utilise a spontaneous UOF or employ personal safety measures. This will often be based on a dynamic risk assessment of the situation.

Incident on 23 July 2017

42. I have considered document CJS007212. I do not know why the resident was not allowed out of his room on this occasion, as I do not think I was there at the time.

43. To my knowledge, not allowing people out of their rooms was not a frequent occurrence. I do not recall there being a specific policy about this and it may have been the responsibility of staff to raise concerns and then make appropriate decisions.

44. I do not recall exactly what I did about this complaint. Normally a complaint like this would be thoroughly investigated and I would have informed senior managers of the incident and the complaint. Given the type of complaint, it is likely to have been sent to the Home Office and the Complaints Department too.

UOF on 2 April 2017

45. I have considered document CJS005635. I do not recall this incident and do not have any further details to provide. I would comment that after looking at the documents referred to by the Inquiry, there are pages missing from the UOF report. There does not appear to be any transcripts which is unusual.

Authorisation of a UOF on a detainee refusing to return to their room

46. I am surprised to see that there is no statement from me as authorising officer contained within document CJS005544. As set out above, it may be that I did provide a statement which has subsequently been lost. In my current role as instructor, I am aware that there is a misconception that authorising officers do not need to complete an Annex A form if they have only led a UOF and not touched the resident. I can only assume that if I did not provide a statement it was human error, or based on this misconception (which due to my relative inexperience, I may have held at the time).

UOF on D2405 on 20 April 2017

47. I have had an opportunity to review document CJS005647 and have a vague recollection of events. The information that I do recall is documented in my report. Having read the statements of other staff members, the narrative appears to be consistent, but I am unable to comment on the perception of others at the time.

48. D2405 was moved to CSU due to him invading officers' personal space and displaying intimidating and aggressive behaviour within a short period of time. I recall that his behaviour was escalating and there were concerns for his welfare and the welfare of others. I remember that D2405 followed me and made me feel very uncomfortable. Ultimately, this resulted in me pushing him away which is a permitted personal safety measure you can implement in such situations.

49. I consider that my use of force was reasonable, necessary and proportionate in the circumstances. Whilst I would always dynamically risk assess a situation, a push was reasonable to move D2405 away from me. I would usually hope to verbally communicate with a resident before utilising personal safety techniques, but this is not always possible if an immediate threat presents itself. The later UOF was also reasonable, necessary and proportionate in the circumstances. As the reports state, only minimal UOF was engaged and guiding holds (which are low level techniques) were used. This was in no way excessive.

UOF Report relating to an assault on D Wing Yard

50. Having considered document CJS005559 I do not recall this incident.

51. I cannot recall the incident, but I am surprised that there is not a statement from me as authorising officer within the documentation. Again, I may have completed a statement at the time which has not been located, or has been lost due to an administrative error.

Incident on 24 April 2017

52. I have reviewed document CJS005558. I do not specifically recall this incident.

53. Having read the report, I understand that I arrived after the incident had taken place. I believe the resident was escorted to CSU and a full search was conducted. As I do not recall this specific incident, I am unable to add anything beyond that which is recorded in the reports.

UOF against D693 on 9 July 2017

54. I do not recall the reasons for this room search. Having read the reports contained within document CJS005562, it is noted that the search was conducted in preparation for a resident to transfer back to prison.

55. Again, I would expect there to have been an Annex A report produced by myself. I can only assume that I drafted a report which has subsequently been misplaced, or that I inadvertently failed to prepare a report.

UOF against D3028 on 18 July 2017

56. Having reviewed the information contained within the UOF report at document CJS007216, I believe that the UOF was necessary in the circumstances. The resident was being moved to CSU due to him exhibiting non-compliant behaviours which included jumping on the netting. The resident became disruptive in the office and then tried to run away. I believe this was an attempt to avoid going into CSU.

57. Smoking is not allowed in Brook House in public places, but the UOF was not used to stop D3028 from smoking. The UOF occurred because of D3028's disruptive behaviour during the preceding timeframe. Had the only issue been D3028 smoking, I would have spoken to him first to ask him to stop. However, in this case, D3028 had demonstrated disruptive behaviour and then ran out of the office having previously jumped on the netting. At the time, we would have been unaware of what

actions he could take. Knowing that D3028 was scheduled to go into CSU, there was a real risk that he could have run into the open area and accessed various tools to use against staff to avoid isolation, for example, pool balls. We were faced with a sudden erratic movement and took appropriate action in all the circumstances.

Incident on 7 March 2017

58. I have reviewed the detailed investigation report contained within HOM003749. I recall this incident. Some of my actions during this UOF were influenced by the resident being naked. This UOF involved a planned intervention for a scheduled deportation flight. When I entered the room, I could see that the resident was naked. At this stage, it would have been inappropriate for me to stop the intervention to swap my assigned staff to an all-male team. Given that the resident was naked, I did everything possible to leave one female member of staff outside his room to limit the number of females present, whilst not putting the resident or staff at risk. I recall that there was one other female present, but that she was responsible for dealing with the other roommate. I believe that the resident may have undressed himself as a tactic to avoid deportation and despite being given the opportunity to put his clothes on, he consistently refused to do so. Had I known that the resident was naked before arriving at his room for the intervention, I would have changed the team to an all-male team if possible. Notwithstanding this, based on my recollection of the UOF and the information in the reports, I believe that I addressed the situation correctly.

59. I recall that I had spoken to the resident earlier in the day, which is when he informed me that he had blades in his mouth. He was using this as a tactic to avoid deportation and I had no concerns whatsoever that he wished to self-harm. Whilst I could have completed a security information report ("**SIR**"), in the circumstances I did not consider this necessary. The most appropriate action was to inform my team during the briefing, which I did, to ensure that they were aware of the potential risk. It is also important to note that it is extremely difficult to forcibly remove items from a resident's mouth. Therefore, attempting to do this earlier in the day, prior to

the intervention, was not a plausible option. I am sure that I asked the resident to safely hand over the blades prior to the UOF event later in the day.

60. I did ask the resident to get dressed and the report confirms this.

Incident involving DCO Murphy

61. I have reviewed document HOM005830. I do not recall this event, so I am unable to comment on it.

Incident on 14 April 2017

62. Having reviewed the report contained at CJS007217, it states that the residents were upset with issues relating to the Home Office. I do not specifically recall the exact issues being protested against.

63. The protestors were peacefully protesting outside and were refusing to move.

64. In such circumstances, staff would try to deescalate the situation to get all residents inside. This would prevent the situation escalating any further and avoid the need for NTRG being called to assist. For example, we would allow people to come back into Brook House, but would prevent others from joining the protest. This might include locking down / restricting certain areas to minimise the flow of people. I believe that there are contingencies for a passive protest and concerted indiscipline. However, these contingency plans are usually opened when the command suite is opened and I cannot recall whether the command suite was opened on this occasion.

65. On this occasion the protest was largely peaceful and we were able to encourage residents to return to their rooms. However, I recall that someone began interfering in a medical incident / began charging at officers which resulted in a UOF. The document I have reviewed appears to be an excerpt from the whole document and there appear to be missing pages.

Incident on 7 March 2017

66. I have considered HOM003718, HOM003719 and HOM003723. I have nothing further to add to my account of this incident.

67. I do not remember this matter being investigated. However, I remember the allegation and I believe it was investigated by the PSU, as per the report. The claims were unsubstantiated and no further action was taken. No disciplinary action was taken either. Please see my further comments at contained at paragraphs 58, 59 and 60 above.

Incident on 9 July 2017

68. I have considered document CJS007218. During the relevant period, residents ordered their food the night before. There was a menu available and one resident would sit at a table and take everyone's orders. This list would then be passed to staff. I recall that breakfast was standardised, but that there were a couple of options available for lunch and dinner.

69. From my recollection, if a resident did not like what they had ordered, they would have to wait until the end to see what was left. If an alternative option was available, they could have that.

70. Residents were expected to dress to an acceptable standard (with a top and bottoms on).

71. Using information contained within the report, it states that the resident was causing disruption to the meal service. He had attempted to grab food and invaded the personal space of officers on more than one occasion. Two officers took control of him to safely remove the resident off the unit and to prevent the incident from escalating any further. Due to the resident's aggressive behaviour and his shouting,

it was deemed necessary to involve two people. I expect that they deemed this appropriate, as matters can escalate very quickly during lunch / dinner due to the number of people in close proximity to one another.

UOF on 23 May 2017

72. I have considered document CJS005646. I did not touch the resident during this planned UOF, but as a supervisor I am surprised that there is no Annex A. Again, my report may have been inadvertently misfiled, or I may have incorrectly not prepared an Annex A due to the misconception I have described at paragraph 46 above.

Incident involving D68 on 7 July 2017

73. I have considered document CJS005560 and I recall that I was on the ground floor by the servery and was talking to another resident. Then, as per the report, another resident came up to me in an aggressive manner and threw a punch. I ducked out of the way but I was not sure whether the punch was aimed at me or the other resident I was talking to at the time. Therefore, I utilised personal safety techniques to swerve back and push the resident with my right hand.

74. I had tried to push the resident in his chest, but had inadvertently pushed his upper chest. I did this as I felt threatened at the time and did not know whether the resident was going to strike again, or cause myself or the resident next to me further injury. I referred to the push within my report for transparency reasons, because as soon as I completed the push, I realised it may have been higher than I had planned. As soon as it was safe to do so, I corrected my positioning and I accurately recorded the incident and my involvement.

75. In the circumstances, it was not appropriate to leave the situation and conduct a planned C&R due to the aggressive approach made by the resident. I dealt with the situation immediately, rather than let it escalate. Had I gone away to plan a C&R, there is a real risk that the resident could have struck me or other residents again. If

I found myself in that situation again, I would take very similar action in order to protect myself and other residents.

Incident involving damaged property

76. I have reviewed document CJS007213. I do not recall what type of staining was on the resident's clothing.

77. I do not recall the specifics of the damage to the DVD player.

78. I do not know who the bag belonged to. I assume it was the resident's bag, but I cannot say for certain.

79. Based on my recollection of policies and procedures effective at the time, room clearances should be conducted with care for the resident and their property and details should be recorded on the appropriate room clearance form.

UOF involving a detainee who was not consuming food / fluid

80. I have considered document CJS007214. In my personal experience, detainees refuse flood / fluid as some form of protest, for example, they wish to be released or are protesting a deportation.

81. It is not possible for me state the frequency of residents taking this action. Abstaining from food / fluid could occur for a number of reasons, for example, due to a religious belief, in protest, or simply because they are not hungry.

82. In accordance with the documents, a planned intervention was necessary on this occasion as there were concerns surrounding the resident's safety and wellbeing. I believe that there was a multi-disciplinary meeting to discuss this and that there were concerns from the healthcare department. The resident was going to be escorted to the Eden wing where he could be better monitored.

83. Each case would be assessed individually, considering the specific resident and the risk to themselves. This would be led by healthcare and a multi-disciplinary team meeting would take place to make the determination. There was no set time limit and it may have been anything from two days (if fluid was not being consumed) or more (if only food was not being consumed).

84. I cannot recall other instances of a planned intervention for food and fluid refusals, so I am unable to comment on the 'normal process'. Such interventions did not take place often.

85. Each case and individual is unique, so it is not really possible to say what is 'normal'. If individuals refuse to see healthcare, this can be normal on some occasions. If they continually refused to see healthcare, other arrangements may have been made, such as observations.

Written warning

86. I have considered document CJS000473. I was issued with a written warning in January 2017 for removing a company document from the office and making it available to a member of staff who had been placed on suspension. This was against company policy and from my recollection, this was the only significant warning that I received. The document I provided was an SIR that had been altered by another individual (I do not recall specifics of who had altered the document). I believe that I handed the SIR to the suspended staff member as I thought it would assist her. From memory, this all related to a verbal altercation between two staff members where bad language was used. I do not recall why I gave the document to the suspended member of staff. I think I was just trying to be helpful, but I appreciate that that was not the correct decision.

87. The only inappropriate conduct was that discussed above.

Incident involving D1978

88. I do not recall this incident in detail, but reviewing the video footage contained at Disk 48 20170523210142_e1606N_0013.mov; transcript of Disk 48 20170523205517_E1606N_0012.mov has prompted my recollection slightly.

89. I cannot recall the exact plan, but the footage indicates that I was going to a wing to conduct a planned removal. I would almost always give someone an opportunity to leave the room peacefully by themselves. From memory, I spoke to the resident and he indicated that he was willing to leave the room and follow me, but I believe there was loud music playing in his room at that time which made it difficult for the team to hear my discussion.

90. I turned away from the door to walk out, expecting the resident to follow me, but it appears from the footage that the team mistook my actions as the resident being non-compliant and went into the room to conduct the planned intervention. This appears to be a complete misunderstanding, where the team entered without my instruction. I believe at one point I tried to stop them as they went through the door, but it was already too late as they had already engaged the resident. The resident became immediately irate and due to his increasingly aggressive behaviour, it warranted the UOF to continue.

91. There were three managers involved in this removal, but I recall that I was in charge. The plan was to allow the resident an opportunity to move by himself, but due to his previous aggressive behaviour there were UOF mechanisms in place if required. As I have described, unfortunately, the team acted before being instructed on this occasion, but this was done in error, rather than in any malicious way.

Incident on 6 June 2017

92. I have reviewed the transcript of KENCOV1021,V20170606000011. I do not recall this incident and the transcript does not provide me with any information which allows me to recall it.

Statement of Truth	
I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth. I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.	
Name	Steven Dix
Signature	Signature
Date	3/2/22