Home Office

HOME OFFICE

Home Office Security
Professional Standards Unit

A Home Office investigation into the circumstances surrounding the detention of D1527 shown on the BBC's Panorama programme Undercover: Britain's Immigration Secret at Brook House Immigration Removal Centre (IRC) between April and June 2017.

IMG Ref:

IMG/17/1555/1557/025

Investigating Officer

Julie Galvin

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1. INTRODUCTION

1.1. On 4 September 2017 BBC's Panorama Programmes showed a documentary called Undercover: Britain's Immigration Secrets. The footage was secretly recorded by Detention Custody Officer (DCO) Callum Tulley while he was employed by G4S at Brook House IRC. The footage showed DCOs, healthcare staff and detainees. D1527 featured in the Panorama programme during three separate incidents, including an incident where a DCO appeared to strangle him while he was held down on the floor by other officers.

1.2. On 21 September 2018 Duncan Lewis Solicitors wrote to the Government Legal Department (GLD) to set out a further challenge to an existing application for Judicial Review in relation to their client D1527, who had been detained at Brook House IRC between 4 April 2017 and 16 June 2017. The purpose of this letter was to request that the Secretary of State institute an independent and impartial inquiry into the treatment of D1527 which they alleged was incompatible with Article 3 of the European Convention on Human Rights (ECHR). It alleged he was subjected to inhuman and degrading treatment and possibly sufficiently severe to cross the threshold for torture whilst he was detained in Brook House IRC.

1.3. On 22 November 2017 Alan Gibson, the Head of Detention Operations requested that the Professional Standards Unit investigate the circumstances of D1527 s detention. The Terms of Reference are detailed below in section 2.

1.4. Following advice from Sussex Police and due to their ongoing criminal investigation, D1527 was not interviewed as part of the investigation but his solicitor confirmed that they would fully co-operate with the Professional Standards Unit investigation and provided evidence for consideration.

1.5. This report sets out the findings and that the level of care afforded to **D1527** fell below the standard the Home Office would expect.

2. TERMS OF REFERENCE

2.1. To investigate the allegations of assault and ill treatment of D1527 against G4S staff, including;

2.2. To investigate the incident from the Panorama programme in which an officer called 'Calvin' boasted that he hit D1527 's head against a table and bent back his fingers, on or around the 9 April 2017.

2.3. To investigate the incident in the Panorama programme of officer Nathan Ring mocking D1527 while he had a phone battery in his mouth.

2.4. To investigate the alleged assault on D1527, on 29 April 2017, by Officer Yan Paschali, who is seen on the Panorama programme footage to be kneeling

over D1527 with his hands around D1527 's neck chocking and verbally abusing him.

2.5. To investigate allegations Officer Yan Paschali directed the nurse not to write up the incident and officers talking about the incident in a derogatory fashion afterwards.

2.6. To investigate whether Brook House IRC officers failed to ensure provision of medical healthcare.

2.7. To consider whether there were any organisational deficiencies which may have contributed to D1527 's treatment, including but not limited to;

2.8. Supervision of officers or detainees; training of officers; suitability of complaints process for detainees and staff.

2.9. To consider and report on whether there is any learning for any individual G4S staff member, or organisational learning for the Home office or G4S, including whether any change in Home office or G4S policy or policy or practice would help to prevent a recurrence of the incident investigated.

2.10. To consider and report on whether the incident highlights any good practice that should be disseminated.

2.11. To consider and report on whether any disciplinary offence may have been committed by any G4S staff member involved in the incident, and whether relevant local and national policies/guidelines were complied with.

2.12. Out of scope – Actual clinical care and allegation of inadequate psychiatric treatment.

3. HOME OFFICE POLICY & GUIDANCE

3.1. Detention Service Order 03/2015 - Handling of Complaints

3.2. Detention Services Complaints Guidance ensures that the investigation of complaints is dealt with effectively and efficiently. This investigation and report has been conducted in line with the formal investigation procedures set out in the Complaints Guidance.

3.3. Detention Service Order 01/2011 – Commissioning of Investigations

3.4. This guidance sets out Detention Services obligation to commission investigations into incidents where Articles 2 and/or 3 of the ECHR may have been breached. This investigation and report has been conducted in line with the guidance.

3.5. Detention Centre Rules 2001

3.6. Rule 40- Removal from Association states inter alia:

3.7. Where it appears necessary in the interests of security or safety that a detained person should not associate with other detained persons, either generally or for particular purposes, 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 arrange for the detained person's removal from association accordingly.

3.8. Where a detained person has been removed from association he shall be given written reasons for such removal within 2 hours of that removal.

3.9. The manager may arrange at his discretion for such a detained person as aforesaid to resume association with other detained persons, and shall do so if in any case the medical practitioner so advises on medical grounds.

3.10. Rule 41-Use of Force states:

3.11. A detainee custody officer dealing with a detained person shall not use force unnecessarily and, when the application of force to a detained person is necessary, no more force than is necessary shall be used.

3.12. No officer shall act deliberately in a manner calculated to provoke a detained person.

3.13. Particulars of every case of use of force shall be recorded by the manager in a manner to be directed by the Secretary of State, and shall be reported to the Secretary of State.

3.14. The duties of Officers of Detention Centres:

3.15. It shall be the duty of every officer to conform to these Rules and the rules and regulations of the detention centre, to assist and support the manager in their maintenance and to obey his lawful instructions.

3.16. An officer shall inform the manager and the Secretary of State promptly of any abuse or impropriety which comes to his knowledge.

3.17. Detainee custody officers exercising custodial functions shall pay special attention to their duty under paragraph 2(3)(d) of Schedule 11 to the Immigration and Asylum Act 1999 to attend to the well-being of detained persons.

3.18. Detainee custody officers shall notify the health care team of any concern they have about the physical or mental health of a detainee.

3.19. **DSO 06/2008 Assessment Care in Detention and Teamwork (ACDT)**

3.20. This DSO provides instruction and guidance for identifying detainees at risk of self-harm and/or suicide; and the subsequent care and support for such detainees, and equally for the staff who care for them. The policy states inter

alia:

3.21. Local protocols must be in place for constant supervision. Constant supervision of a detainee will be carried out by a designated member of staff on a one-to-one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly (depending on local protocols).

3.22. At-risk detainees should not normally be isolated and should be kept in association wherever possible

3.23. **Safeguarding Policy (April 2017)**

3.24. This policy states inter alia:

3.25. all vulnerable persons will be valued and respected, they will be listened to and their views and concerns responded to; they will be encouraged to take an active part in the planning process, so that they can influence and help shape decisions affecting their stay in the centre.

3.26. Supported Living Plan documents will be used to monitor vulnerable detainees within detention. The plans will reflect any reported claims of abuse / torture.

3.27. Detainee Custody Managers will attend multi agency reviews to ensure the vulnerable person's needs are still being met.

4. OFFICER SUBJECT TO INVESTIGATION

4.1. DCM Nathan Ring

4.2. DCO Kelvin Sanders

4.3. DCO Charlie Francis

4.4. DCO Clayton Fraser

4.5. DCO Yan Paschali

4.6. DCO Callum Tulley

4.7. All the officers above are no longer employed by G4S. For ease all officers are referred to by their role at the time of the Panorama recording in April 2017.

5. SUMMARY OF INVESTIGATION

5.1. On 4 September 2017 the BBC showed Undercover: Britain's Immigration Secrets.

5.2. On 14 September DCO Paschali was interviewed by the Investigating Officer in connection to another matter. He was asked to respond to the allegations against him shown on Panorama.

5.3. The Panorama programme was considered by Sussex Police to identify any criminal actions by the officers. They have an ongoing criminal investigation into the actions of DCO Paschali against D1527

5.4. DCO Paschali and DCO Tulley left G4S' employment before the programme was broadcast. They were not invited to participate in this investigation on the request of Sussex Police who have an ongoing criminal investigation into the actions of DCO Paschali.

5.5. DCM Nathan Ring, DCO Kelvin Sanders, were instantly dismissed from G4S following the allegations made by the Panorama programme. DCO Francis and DCO Fraser were subjected to G4S misconduct investigations and were subsequently dismissed. All these ex-officers were invited to take part in this investigation; only DCO Sanders responded and agreed to contribute. The G4S misconduct interviews given by DCO Sanders, DCO Francis, Nurse Buss and other G4S employees have been considered during this investigation.

5.6. On 21 September 2017, Duncan Lewis solicitors wrote to GLD to request an investigation into the treatment of D1527 as shown on the Panorama Undercover: Britain's immigration Secrets.

5.7. On 17 November 2017 the Professional Standards Unit were commissioned to investigate the complaint and Julie Galvin was assigned as the Investigating Officer

5.8. On 5 December 2017 the Investigating Officer met Sussex Police officers and it was confirmed that the Investigating Officer should not interview D1527 or DCO Tulley as they were witnesses in an ongoing criminal investigation, nor DCO Paschali as he was subject to an ongoing criminal investigation. The Investigating officer was able to obtain written evidence from D1527

5.9. On 7 December 2017 the Investigating Officer wrote to Duncan Lewis Solicitors to request that D1527 submitted any further written information he would like to be considered.

5.10. On 22 December 2017 Duncan Lewis Solicitor's wrote to the Investigating Officer setting out further concerns and areas for investigation.

5.11. On 25 January 2018, DCM Steven Loughton was interviewed at Brook House IRC.

5.12. On 30 January 2018 the Investigating Officer interviewed Mr Kelvin Sanders at Gatwick Police Station.

5.13. On 12 February 2018 G4S confirmed DCO Aaron Stokes resigned from G4S' employment in August 2017. He was the officer who was present when DCO Sanders alleged officers discussed the use of force and it was DCO Stokes who made the comment that if the officer turned around, hopefully D1527 would be swinging. DCO Stokes was not invited to respond to the allegations during this investigation.

5.14. On 14 February 2017 the Investigating Officer interviewed DCM Michael Yates at Brook House IRC. However the Investigating Officer decided not to interview DCM Dix regarding the incident of 4 May 2017 as his written reports provided sufficient detail and these were completed contemporaneously and video footage was available in the form of CCTV and the body worn camera footage.

6. SUMMARY OF EVIDENCE

D1527 'S COMPLAINT

I1 6.1. In D1527 's solicitor's letter of 21 September 2017 the following allegations related to the Panorama programme were raised:

6.2. Footage of an officer called "Calvin" boasting that he had hit D1527 's head against a table and bent back his fingers and later bragged about it;

6.3. An assault where D1527 he was pinned to the ground, strangled, threatened and humiliated by one officer while others watched;

6.4. Deliberate threats and intimidation. Officers are recorded saying things to our client including "*Don't fucking move, you fucking piece of shit. I'm going to put you to fucking sleep.*" … "*are you going to stop being a tool now, are you? Are you going to stop being an idiot? Yes or no? Yes or no?*" (while strangling D1527 D1527

6.5. Following these incidents, there were concerted steps to conceal these violations by way of deliberate cover-ups and deliberate failures to record and report the above treatment by whole groups of officers and by medical staff;

6.6. Deliberate degrading psychological bullying by officers; "*Plug him in and he'll be a Duracell bunny. Fully charged*" … "*If he wants to suck on a battery he can suck on a battery. If that's what he wants to use as his dummy, fine. I'm happy with that*" … "*Going on like's he's fucking three*" … "*Come on, we're getting bored of this now. Come on. Oi. What are you? A man or a mouse? Come on, stop being a baby*".

6.7. Derogatory and degrading talk about the client to other officers and medical staff such as "*a right prick*"; "*You've got to have the urge to punch him in his face*"; "*Turn away and hopefully he's swinging, probably*"; "*He's an arse*".

6.8. In addition D1527 was repeatedly removed from association and put into segregation and repeatedly locked in his room which was as an unacceptable means of managing his mental illness and/or as punishment for his disturbed behaviour.

I2 6.9. In their letter to the PSU dated 22 December 2017 D1527 's solicitor set out further allegations, many related to systematic failings at Brook House IRC and in relation to D1527 they raised concerns that:

6.10. D1527 experienced racism at times from IRC staff, including, he said, a guard who had said to him aggressively "*what do you need to go to the fxxxing* Sensitive/Irrelevant *for?*" when he had asked for leave from E-Wing to attend Sensitive/Irrelevant D1527 D1527 said that he has also experienced other IRC guards threatening to deport him, swearing at and/or disrespecting him or his religion. His view is that this does not occur to other detainees as much as he, from his own observations and he considers that this may be due to IRC officers coming to conclusions about him based on his case file, particularly assuming that he is a sexual offender.

6.11. The Panorama footage showed that guards colluded with the staff nurse not to write up the strangulation assault on D1527 on 25 April 2017 as a control and restraint incident. This meant, inter alia, that the following day the doctor that saw him was unaware that he had been assaulted the previous day and that no psychiatric treatment was offered to him in response.

6.12. D1527 raised issues with healthcare staff, they were not dealt with in accordance with medical standards or relevant procedures. Nobody sought to deal with complaints that were raised nor sought to allow their client access to a complaints procedure.

6.13. On 4 May 2007 D1527 was assaulted in his cell following the incident during which he went onto the suicide netting.

I3 6.14. In addition to their letter, D1527 's solicitor submitted a psychiatric report by Dr Amlan Basu. This included the details from his interview with D1527 which set out further allegations that:

6.15. On 25 April 2017, staff forcibly removed the battery from D1527 mouth.

6.16. D1527 had no faith in the complaints process.

6.17. On 4 May 2017 the incident when D1527 went on to the netting to protest started when a canteen worker refused to give him a plate as she claimed he had already eaten. When a plate was finally given to D1527 he broke it, took a shard of the broken plastic and jumped onto the netting. He was talked down by two detainees and he went into their room. Following this around six guards rushed the room and dragged him forcibly to E-wing when excessive force was used.

6.18. **TIMELINE**

A 6.19. Attached at the end of this report is a timeline for reference, which sets in chronological order out the documentary evidence and video evidence, including the Panorama footage. D1527 's medical records, whilst made available to the Investigating Officer are not routinely referenced.

6.20. **EVIDENCE OF RESPONDENTS**

6.21. **Evidence of Yan Paschali**

6.22. During an interview related to another matter DCO Paschali was asked for his response to allegations made in Panorama. He responded that the programme only showed a very small part of what happened on 25 April 2017. D1527 tried to hurt himself and take his life quite a few times that day. On this particular occasion DCO Paschali believed whole-heartedly that D1527 was attempting to swallow something which could potentially kill him, or harm him and this was not shown on the programme at all.

6.23. He recalled there was a fight going on between an officer and the detainee, so they took him to the ground. DCO Paschali acknowledged that the words he used at the beginning were shocking to anyone watching, but this was to gain control and to shock D1527 into compliance, which he believed he achieved. DCO Paschali stated that he actually said *''don't move you fucking piece of shit I don't want to put you to sleep'',* but Panorama wrote in the subtitles *''I'm going to put you to sleep''*. The words sounded terrible but it achieved what he wanted and D1527 stopped.

6.24. DCO Paschali stated he was taught to have a detainee's head between his legs and brace one hand on the forehead and another on the chin. He did not do this because he did not want D1527 to swallow the article, which he thought was a phone battery, but could have been razor blades. He believed he stopped him from swallowing it and saved his life. He stated that whilst the reported stated he was strangling D1527 he was not as D1527 was able to scream and shout. DCO Paschali stated he remained calm and he wanted D1527 stop moving to calm the situation down. He did not want to put his fingers in D1527 's mouth as he could be bitten.

6.25. DCO Paschali stated at one point his hand was resting on his thigh, he was not throttling D1527 He did not stop D1527 breathing. His hands were not digging into his throat, he was supporting his neck. He stated if he was throttling someone his arms would move, but his were still. He considered that DCO Tulley overreacted and was behaving weird and he said to DCO Tulley *''Callum, will you calm down, calm down everything is under control.''* He gestured for him to calm down by waving his hand. DCO Paschali stated his justification for his hands being where they were, was that he thought it was necessary at the time and justified as he did not want D1527 to swallow what is in his mouth. He had to do something to try to help.

6.26. DCO Paschali stated that D1527 shook his hand later and thanked him. He did not complain.

6.27. DCO Paschali stated that he did write a use of force report and he believed that DCO Tulley disposed of it. DCO Tulley came up to him after the incident saying *''are we doing a report?''* He replied *''as it stands hold fire''* as he had other detainees to deal with who needed his attention. He considered that DCO

Tulley asked him the question not because DCO Tulley did not know what to do, but because DCO Tulley was trying to paint a picture of DCO Paschali and G4S. DCO Paschali stated he did not discuss writing the report, or not writing a report, with anyone else.

I4 6.28. **Evidence of Kelvin Sanders**

6.29. DCO Sanders worked at Brook House IRC as a newly recruited DCO from 23 January 2017 until 22 May 2017 when he moved to Tinsley House IRC. He was dismissed from G4S following the Panorama programme being broadcast when he was shown stating that he banged D1527 's head and bent his fingers back..

6.30. DCO Sanders recalled he was the first person to start the constant observations on D1527 on 24 April 2017, following D1527 self harming. Initially DCO Sanders sat outside the room but D1527 tried to hurt himself so DCO Sanders went inside the room, as per ACDT policy, and sat on the table next to D1527 to try to talk to him. (This was shown on Panorama). DCO Sanders stated that D1527 was lying on his bed and kept trying to put his fingers around his throat trying to strangle himself and he kept banging his head on the table. DCO Sanders tried to put a pillow under D1527 head to stop him doing this.

6.31. After an hour or so D1527 sat up and spoke to DCO Sanders, initially with one word answers. Where D1527 had tried to strangle himself he had ripped his clothes so DCO Sanders arranged for some more. DCO recalled that D1527 would not speak to anyone else at that time, including the religious leader DCO Sanders stated that D1527 requested that DCO Sanders continued to do the constant observations after his break and so DCO Sanders watched D1527 D1527 for four hours that day. DCO Sanders escorted D1527 to the Sensitive/Irrelevant and D Wing courtyard, which he said was not meant to happen while a detainee is on constant observations.

6.32. DCO Sanders stated that he did not twist D1527 hand or bang his head as he had stated on Panorama. DCO Sanders stated that he felt he bonded with D1527 on that day.

6.33. DCO Sanders explained why he fabricated this story. He stated that he was with a few officers including DCO Tulley and they were all swapping stories on C&R. DCO Sanders said he hurt D1527 to try and match them, to get the officers to like him and to fit in. DCO Sanders stated that the constant watch was the only opportunity DCO Sanders had to say he had done 'something'. He repeated the same story another time to other people, trying to keep the story consistent in case it was discussed by the different officers.

6.34. DCO Sanders stated that during this conversation the other officers did not say they abused detainees but they discussed how much of a fight the detainee put up during C&R, how they got the C&R over quickly, and that they felt 'pumped'. One officer from Tinsley House said he smashed detainee with a shield and hit him so hard he cut his knee. He did not recall any other DCO saying they hurt a

detainee. DCO Sanders stated he did not wish to name any officers but officers said they had '*done thumb things and stuff*' and when they were the head officer to get the detainee to stop squirming they would squeeze the detainee's throat a bit.

6.35. DCO Sanders stated that he did not feel able to say he helped a detainee as '*it was a guy thing, if you say that they say you are a pussy*'. DCO Sanders did not want to be bullied at work and wanted to fit in.

6.36. DCO Sanders agreed he said ''*you are an intention seeking little prick aren't you*'' to colleagues, but he stated he did not say that to D1527. On Panorama he said ''*I don't have any sympathy for any of them*'', but he stated that was not true. He said whilst he said it was ''*funny*'', it did not happen. DCO Sanders stated that he would like to apologise to D1527 for what he said on the show; he was stupid for what he said and he regretted it.

I5 6.37. **Evidence of DCM Loughton**

6.38. DCM Loughton was Oscar 1 (duty Manager) on 25 April 2017. He attended E Wing around 19:00 hours to review D1527 s ACDT to see if there was any record of him eating or drinking. When he got to the room DCO Fraser was on constant watch and looking through the window. DCM Loughton asked if D1527 D1527 was OK and DCO Fraser said he could not see him as he was in the toilet area. DCM Loughton said they had to go in and unlocked the door. D1527 was laid around the toilet with some sort of ligature around his neck. DCM Loughton got a fish knife and told DCO Fraser and DCO Tulley, who had arrived, to call for First Response. DCM Loughton cut the ligature from around D1527 's neck and managed to pull him out a bit. He could see D1527 was breathing and conscious. Healthcare then turned up.

6.39. DCM Loughton was trying to calm him down but he was very irate and he saw D1527 put a phone battery in his mouth and said ''I'm going to swallow this''. DCM Loughton managed to get D1527 to sit on the bed.

6.40. When DCM Loughton turned around and loads of people had turned up; healthcare, Oscars, so many people. He explained to healthcare that D1527 had a ligature around his neck and put a battery in his mouth. They were trying to talk to him but he was upset and angry. He still had the battery in his mouth, which he refused to hand over, but he did calm down.

6.41. Healthcare was present, DCM Ring was there, and many officers so DCM Loughton left to write his report. He went back to his office. He was not aware of the subsequent use of force by DCO Paschali.

6.42. DCM Loughton stated that he should have been made aware of the incident as he had to oversee the correct reports were completed and notify the Home Office, the Duty Director and Healthcare, although they were present.

6.43. DCO Loughton stated that he spend a lot of time on E Wing as it was probably the most challenging wing. The officers on Panorama were all experienced staff

and he had no problem scheduling those staff to work there.

6.44. DCM Loughton stated that DCO Tulley had begged him not to put him on a C&R in the past, and he did not volunteer to get involved in planned interventions. DCO Tulley then had some time off and then he asked DCM Loughton to be involved in any planned C&Rs and DCM Loughton did not think anything of it. Therefore, he got DCO Tulley involved.

6.45. DCM Loughton was often Oscar 1 and therefore attended all emergency incidents along with First Responding officers and Healthcare. DCM Loughton recalled that DCO Tulley was there at every first response, not in the middle of things but in the background, and now he knew why. DCM Loughton remembered an incident shown on Panorama when he lifted a detainee onto a chair, and he remembered turning around and seeing DCO Tulley standing there and he said ''Callum why are you

I6 6.46. **Evidence of DCM Michael Yates**

6.47. DCM Yates recalled the 24 April 2017 but not the specifics of what happened. His only recollection was DCM Loughton informed him D1527 swallowed a battery. He was newly promoted and shadowing manager DCM Steve Dix on that day. He attended E Wing at around 19:06 hours when he remained outside D1527 's room, CCTV showed he left a few minutes later.

6.48. DCM Yates returned to E Wing at around 19:21 hours. The CCTV showed he entered D1527 's room at around 19:22 hours with DCO Fraser and DCM Ring. DCM Yates believed D1527 had gone to the toilet area and therefore he could not be seen by the officer on the constant supervision so they entered to see D1527 was OK. He did not recall what occurred but he did not believe it was anything significant. CCTV showed Healthcare staff remained outside the room. DCM Yates stated that healthcare staff would not necessarily enter a detainee's room during an incident and may wait outside until they were needed. He did not recall that D1527 self-harmed or that first response were called, although CCTV showed more Healthcare staff did come to the scene.

6.49. DCM Yates stated that the attendance of further officers depended on whether officers involved in an incident called for assistance. If there was a spontaneous use of force officers should press their panic button at the first opportunity. First response will then attend. As an alternative, if an immediate response is not required by a manager and healthcare are already present, an officer can make a radio call for a manager to attend the scene in slower time; but a manager must be informed of the use of force. DCM Yates did not know the policy which refers to this. He was aware D1527 was a prolific self-harmer and to protect his life force would have to be used but he was never made aware of the use of force by DCO Paschali.

6.50. CCTV showed DCM Dix and DCM Yates attended D1527 's room immediately after DCO Paschali used force on D1527 and examined the paperwork at the door. DCM Yates did not recall what was discussed, but he

stated there was no mention that force had just been used on D1527.

6.51. Regarding the events of 4 May 2017, DCM Yates was shadowing DCM Dix and they were called to the incident when D1527 was on the netting. He described D1527 as belligerently shouting while people tried to calm him down. The crowd was dispersed and D1527 's friends persuaded him to get off the netting and he went into their room.

6.52. DCM Yates attended the room with DCM Dix and he told two other officers to wait outside. DCM Dix tried to calm D1527 down and explained to D1527 D1527 that he to walk with the officers to CSU because he had been on the netting. His friends were telling him to go with them. D1527 then rummaged in his pocket and it looked like he was grabbing hold of something. DCM Dix asked him to take his hand out of his pocket and D1527 responded along the lines of "you will see what I have in my pocket" and made the movement that he was taking something out so DCM Dix spontaneously took control of his hand. The other officers had heard the commotion and entered the room. DCM Yates grabbed hold of D1527 s right hand, DCM Bromley his other hand and DCO Shaukat held D1527 head. DCM Yates and then presented D1527 D1527 s right hand to the small of his back and handcuffs were put on.

6.53. As they left the room D1527 was screaming, shouting, and thrashing about. As they left the wing D1527 started to struggle again. He stated D1527 was babbling and was actively trying to prevent them from taking him to CSU. DCM Dix led the communication with D1527. DCM Yates did not recall using the thumb inflection as he had written in his use of force report. On reading his report DCM Yates stated that this was used as they left the wing and D1527 struggled. He would have used it to get D1527 to walk with them. A thumb flexion is pain compliance and the technique is to push the thumb into the detainees hand for up to 5 seconds, after the detainee was warned. He was not aware of any other officer applying pain compliance to D1527 D1527

6.54. At the top of the staircase D1527 took a dislike to DCM Yates and he refused to walk down the stairs if DCM Yates controlled his arm, so it was agreed DCM Dix would take over control of his right hand and DCM Yates left and had no further involvement with the relocation of D1527 to CSU. He believed it continued without incident.

6.55. DCM Yates stated DCMs were expected to wear body worn cameras. This was not a planned use of force. The only reason the incident ended in the use of force was that D1527 looked as if he was taking something out of his pocket. Once a detainee had been on the netting, they were taken to CSU and placed on Rule 40 because this action was a danger to the detainee, may incite others to take similar action and it would be time away from association. All detainees are placed on constant supervision for one hour following the use of force.

I7 6.56. **Evidence of Jon Collier, Head of Centre at the National Tactical Response Group (NTRG) of HM Prison & Probation Service.**

6.57. Jon Collier was asked to provide an expert statement on the use of force by DCO Paschali on 25 April 2017. His statement stated inter alia:

6.58. The positioning of DCO Paschali is as that described and taught during training. The detainee is on his back and the knees of DCO Paschali are alongside the head. This is designed to prevent any excess movement of the detainees head and reduce the risk of injury, either self-inflicted by the detainee or by the struggle taking place and any resistance to the restraints being applied by the staff. The position of the hands within the manual and during training is described as; Number 1 (the description of the head support officer, who takes control of the team) places one hand on the forehead of the prisoner (in this case detainee) keeping the head securely on the floor without applying any undue pressure. The footage clearly shows the hand position being around the neck of detainee D1527*, and the thumbs of DCO Paschali being driven into the neck/throat area.*

6.59. The pressure used by DCO Paschali was more to the centre of the neck and appeared to be either side of the windpipe. His actions appear deliberate and not a simple misapplication of an approved technique. The verbal dialogue given by DCO Paschali does not reflect the communication strategy expected of staff. Rather than trying to calm the situation and encouraging the detainee to comply he is offering a more confrontational attitude and offers little or no genuine effort to de-escalate the situation and to reassure the detainee that staff are acting in his best interests.

6.60. **G4S Investigation evidence**

6.61. Panorama made allegations about 16 members of G4S staff, 14 of which still worked at Brook House IRC. Paul Kempster, the Chief Operating Officer for G4S custodial and Detention service, commissioned Peter Small, Director, and HMP Rye Hill to investigate these allegations. The interviews of the officers involved in the allegations related to D1527 have been reviewed.

I8 6.62. **Evidence of DCO Clayton Fraser**

6.63. DCO Fraser was investigated by G4S for failing to document the use of force during which a fellow officer choked a detainee in an attempt to render him unconscious. DCO Fraser stated during that interview he was carrying out a constant observation of D1527 on 25 April 2017. He recalled a number of events of significance which he omitted to record in his constant observations records. He stated that he saw D1527 put a phone battery in his mouth and then he signalled to a colleague for assistance. This colleague opened the door. D1527 was agitated and demanding to be let out of his room. DCO Fraser replied that he would have to ask a manager. D1527 started putting paper on the window of the door and a manager attended and said he would not be allowed to leave the room. DCO Tulley took over the constant observations of

D1527 while DCO Fraser had a break.

6.64. On his return DCO Fraser stated he observed through the door that D1527 had put a t-shirt around his neck and was by the toilet. DCO Fraser, DCO Tulley and an unknown manager (identified as DCM Loughton) entered the room and the DCM cut the ligature using DCO Fraser's knife. D1527 then drank some water, washed his face, lay on his bed and calmed down.

6.65. DCO Fraser stated D1527 then became disruptive again and he returned to the toilet area where he could see his legs sticking out. DCO Fraser and DCO Tulley entered the room and heard D1527 was making choking sounds as if he had something in his mouth, DCO Tulley said *"stop it, stop it"* and they moved D1527 to the middle of the room. D1527 was thrashing his legs and DCO Fraser attempted to prevent this by holding his legs, he then ran to the door to call for assistance. DCO Paschali entered the room and took control of D1527 's head, DCO Tulley held D1527 's left arm but he did not recall who held D1527 other arm. DCO Fraser stated he initially had his back to these officers when holding D1527 's legs and then he moved to the door from where he did not hear or see what happened as shown on Panorama as the officers leaning over D1527 blocked his view.

6.66. DCO Fraser stated he did not complete a use of force report for initially holding D1527 's legs but on reflection he should have. It was nearly home time. He was not pressured by someone else into not completing a use of force report.

6.67. DCO Fraser stated that DCO Tulley spoke to him about the incident around 2 May 2017 and DCO Tulley had said DCO Paschali had attempted to put a choke hold on D1527 . DCO Francis responded that DCO Paschali was maybe trying to put him to sleep of prevent him from swallowing a battery. DCO Fraser later made a comment that the *'best way to deal with* D1527 *was as Yan had'*, as DCO Tulley had told him what DCO Paschali had done. DCO Fraser insisted he had not seen it himself. G4S substantiated both allegations based on the Panorama footage and DCO Fraser was dismissed.

I9 6.68. **Evidence of DCO Charlie Francis**

6.69. DCO Francis was investigated by G4S for failing to document the use of force during which a fellow officer choked a detainee in an attempt to render him unconscious. DCO Francis stated that he was on duty on 25 April 2017 and he and officers had to go into D1527 room a couple of times because he *'ligatured'*. DCO Francis described D1527 as *'needy'*. He recalled that around 17:00 hours DCO Paschali called for assistance and they pulled D1527 D1527 out from the toilet area because he had *'ligatured'*. DCO Paschali used DCO Francis' fish knife to cut the ligature then healthcare and many others arrived and were at the door.

6.70. Later D1527 was shouting and screaming and DCO Francis told him to *"man up"* D1527 then tried to self strangulate with his hands. DCO Francis was returning to the Care and Separation Unit (CSU). He stood by the door and D1527 was sat on the bed and DCO Paschali was in the room but there

was no restraint by officers. It was put to DCO Francis that he entered the room at 19:34 hours and did not leave until 19:42. DCO Francis stated he did not lay hands on D1527

6.71. DCO Francis was shown the Panorama footage and he then agreed he must have held D1527 's right arm during the restraint with DCO Paschali. He agreed it was his voice saying *"are you a man or a mouse?"* DCO Francis explained that he would have said this as he would be trying to bring D1527 back to reality. DCO Francis had heard D1527 choking and he was asked what he did to stop DCO Paschali restricting D1527 's airways. He stated he nudged DCO Paschali who he described as '*bullish*'. He was concerned DCO Paschali had gone too far and it could be close to illegal, which is why he did not write a use of force report. He admitted he should have reported it but he could not explain why he did not. He agreed that D1527 was in a horrid position and he should have done more to stop DCO Paschali.

6.72. The G4S allegations against DCO Francis were substantiated and he was dismissed.

I 10 6.73. **Evidence of Clinical Lead Jo Buss.**

6.74. Nurse Buss was interviewed by G4S investigators. Panorama showed Nurse Buss calling D1527 "*an arse basically*" when she was asked what was wrong with him by DCO Tulley. Nurse Buss could not recall the shift and she did not recall the incident shown on Panorama where DCO Paschali was shown with his hands around D1527 's neck. She agreed that it was a use of force but she did not recall it.

6.75. Nurse Buss was shown an ACDT constant watch entry from 19:40pm on 25th April 2017 and she confirmed that she made the entry and that it was her handwriting and notes.

6.76. Nurse Buss was suspended from her position at Brook House IRC and NHS England were considering whether there was a case for misconduct,

I 12 6.77. **Evidence of DCM Dix**

6.78. DCM Dix was interviewed as part of the G4S investigation as a witness because he was the first manager on site following an incident. DCM Dix stated that attended E Wing minutes after the use of force by DCO Paschali on D1527 D1527 on 25 April 2017. It was put to DCM Dix that he entered D1527 's room but he did not document the conversation on D1527 records. DCM Dix stated that he should have documented the conversation, but he did not recall what he said to D1527

6.79. DCM Dix stated he did not read Nurse Buss' entry at 19:40 hours in the constant observations at the time.

6.80. DCM Dix did not recall any conversations with DCO Tulley as they passed by each other, nor did he recall what DCO Paschali told him as CCTV showed they

spoke. As the first manager on the scene after a use of force, he would have advised the officers to submit their reports to the Oscar 1. He was unsure what duty he was on that day.

7. CONSIDERATION OF EVIDENCE AND CONCLUSIONS

7.1. **To investigate the allegations of assault and ill treatment of D1527 against G4S staff, including;**

7.2. **Allegation**

7.3. **To investigate the incident from the Panorama programme in which an officer called 'Calvin' boasted that he hit D1527 head against a table and bent back his fingers, on or around the 9 April 2017.**

7.4. **Review**

7.5. The Panorama footage showed DCO Sanders on constant observations with D1527 D1527 is lying on the bed. A pillow is visible on the bed. Part of the conversation is heard:

DCO Tulley- If you want me to take over just give me a shout.
DCO Sanders- I'll get through to him eventually.
DCO Tulley - What's he been doing?
DCO Sanders -He keeps trying to put his hand around his neck and dig it in like that. DCO Sanders is seen putting his fingers to his neck.

7.6. DCO Tulley was then shown talking to the camera saying DCO Sanders later told him what he got up to when no one was watching.

7.7. DCO Sanders - *I was sat on the table next to him, literally I was talking and obviously went out to make sure no one was watching, as he banged his head, as he's banging on the bounce I went bang* (DCO Sanders bangs hand down) *and sort of held it there. And he was trying to do that to himself, push his finger into his neck*, (DCO Sanders showed two fingers) *so I got his finger and thumb* (DCO Sanders bends his fingers back) *to stop him doing it*. (DCO Sanders is smiling). *It was funny…You know you're hurting yourself cos you are attention seeking you little prick…I don't have any sympathy for any of them".*

7.8. DCO Tulley was then shown talking to the camera saying that these comments were not challenged as they are common place.

7.9. DCO Sanders was then shown with another officer, DCO Aaron Stokes.

7.10. DCO Sanders - *He's being a right prick so when he went like that, (*puts finger to his neck*), I fucking went like that (*pushes fingers away*) DCO Sanders laughs.*
DCO Stokes- *you've got the urge to punch him in the face when he went up, bang.*
DCO Tulley -*What's the best way to deal with someone like that?*

DCO Stokes- *Turn away and hopefully he's swinging, probably.*

7.11. G4S dismissed DCO Sanders following the broadcast of the Panorama programme. DCO Sanders agreed to provide his account to this investigation. He stated that whilst he had said these comments to colleagues on two separate occasions, he did not hurt D1527 and he made this up.

7.12. The ACDT on-going records confirmed the only time DCO Sanders was on constant supervision of D1527 was on 24 April 2017. The Panorama footage showed that DCO Sanders was on the desk in D1527 's room with D1527 lying face down on the bed next to him. DCO Sanders explained that as D1527 was trying to hurt himself he did not think it was appropriate to sit out side the room and simply observe. Instead he sat next to D1527 so he could prevent his self-harm attempts and engage with him to encourage him to stop.

7.13. Records showed that DCO Sanders started his constant observation at 15:40 hours when D1527 was crying. DCO Sanders records state:

15:52 D1527 *was banging his head on the base of his bed repeatedly I went in to prevent him doing any further damage.*
16:03 D1527 *is trying to drive his index finger either side of his neck with extreme pressure- I have asked him to stop or I will place hands on his hands to pull them away to prevent him injuring himself*
16:16 hours D1527 *keeps banging his head on the base of his bed I am trying to talk him out of it and to sit up and talk to me so I can try to help.*

7.14. There was no footage on Panorama of DCO Sanders hurting D1527 although on the programme DCO Sanders stated that he went to the door to ensure there were no witnesses. Such additional comment seemed superfluous if the story it was untrue. On reviewing the other recorded observations this would appear to have been the most likely time that DCO Sanders hurt D1527 D1527 DCO Sanders stated that in reality he placed a pillow under D1527 head to try and stop him banging his head as the mattress had moved down the bed and he was lying on the bed base. He did not record this in his on-going observations, although a pillow was visible on the bed to the side of D1527 on Panorama.

7.15. DCO Sanders stated that he tried to help D1527 rather than hurt him. He stated that he engaged with him and successfully built a rapport with D1527 D1527 which was reflected in the on-going record at 16:47 hours when DCO Sanders commented that D1527 *has engaged in conversation and is now talking to me, wished to go to* Sensitive/Irrelevant

7.16. Whilst DCO Sanders refuted that he hurt D1527 , he was shown on Panorama on two separate occasions boasting to officers that he had done so. DCO Sanders stated that he consciously kept his story consistent in case officers discussed his comments. If true, this appeared to indicate a considered effort to lie and be believed. The first occasion DCO Sanders was shown on Panorama saying he hurt D1527 appeared to show DCO Sanders talking to

DCO Tulley only, and although other staff were heard in the background talking, they did not appear to be part of DCO Sanders conversation. Their full conversation was not shown, but DCO Tulley was shown on Panorama being mocked by other officers for not liking to use force and therefore it was unclear why DCO Sanders considered stating he had hurt D1527 would help him befriend DCO Tulley.

7.17. On the second occasion, there were other officers present but his conversation was with DCO Stokes who no longer worked at Brook House IRC. DCO Sanders said that the other officers were talking about their use of force stories, although the other officers did not say they had hurt detainees. The other officers' comments were not broadcast on the Panorama programme. DCO Sanders explained he was wanted to fit in and therefore could not say he had tried to help D1527 which he said was the truth, as there was a macho culture and he would be considered '*a pussy*' and he did not wish to be bullied at work.

7.18. **Conclusion**

7.19. DCO Sanders stated that he would like to apologise to D1527 for what he said on Panorama and he accepts he should not have said what he did, but he denied hurting D1527

7.20. To DCO Sander's credit, he volunteered to participate in the investigation and provide an explanation for what he had said, something he did not need to do. DCO Sanders stated he fabricated his story that he hurt D1527 to fit in, yet Panorama did not show the other officers boasting about similar acts. DCO Sanders explanation was that he had lied to his colleagues and this undermined his personal integrity. Whilst there is no proof DCO Sanders hurt D1527 the extent of DCO Sanders descriptions and his willingness to talk about what he had done, suggested that on balance, it was more likely than not to have occurred, and that DCO Sanders did hurt D1527 as he stated. Therefore the allegation is substantiated.

7.21. Detention Centre Rules state DCOs exercising custodial functions shall pay special attention to their duty under paragraph 2(3)(d) of Schedule 11 to the Immigration and Asylum Act 1999 to attend to the well-being of detained persons. DCO Sanders statements to his colleagues in saying he had hurt D1527 D1527 and calling him *''an attention seeking prick''* were derogatory and were likely to have degraded D1527

7.22. **Allegation**

7.23. **To investigate the incident in the Panorama programme of Officer Nathan Ring mocking D1527 while he had a phone battery in his mouth.**

7.24. **Review**

7.25. The Panorama footage showed DCM Ring jumping up and down saying *''plug him in he'll be a Duracell bunny' '' If he wants to suck on a battery he can suck*

on a battery" " If that's what he wants to use as his dummy, fine I'm happy with that"

7.26. DCM Ring was dismissed by G4S without interview, following the Panorama programme broadcast. DCM Ring was invited to participate in this investigation but he declined. Therefore there is no explanation provided by DCM Ring for consideration.

7.27. Detention Centre Rules state '*Detainee custody officers exercising custodial functions shall pay special attention to their duty under paragraph 2(3)(d) of Schedule 11 to the Immigration and Asylum Act 1999 to attend to the well-being of detained persons'.* The evidence showed DCM Ring mocked D1527 in front of other officers and this was considered degrading.

7.28. For balance, as DCM Ring has not contributed to this investigation, it was noted that there was evidence that DCM Ring had shown D1527 an appropriate level of assistance on 24 April 2017. DCM Ring was the duty manager who conducted an ACDT case review. D1527 was upset and wanted to return to his room on C Wing in addition his possessions had not been cleared from his old room. DCM Ring took action and called C Wing to see if D1527 could have his old room back but another detainee had already moved in. D1527 was upset and angry about this and DCM Ring, recognising this, told his officers to watch D1527 D1527 then attempted to strangle himself in his room and officers intervened, including DCM Ring who cut D1527 ligature. He then assigned an officer to constantly supervise D1527 DCM Ring also created two new actions on D1527 care plan to address D1527 's issues at that time, including that D1527 was not sleeping well and needed a medical appointment. Therefore whilst Panorama showed DCM Ring only in a negative light, mocking detainees and disregarding policies, this evidence showed that this may be a misrepresentation.

7.29. **Conclusion**

7.30. The Panorama footage clearly showed DCM Ring talking to D1527 in a manner that was unprofessional and may be considered derogatory. These were not in line with the expected behaviours of the manager who is responsible and duty bound to assist a vulnerable detainee. Therefore the allegations are substantiated.

7.31. **Allegation**

7.32. **To investigate the alleged assault on D1527 on 25 April 2017, by Officer Yan Paschali, who is seen on the Panorama programme footage to be kneeling over D1527 with his hands around D1527 's neck chocking and verbally abusing him**.

7.33. **Review**

7.34. Panorama showed DCO Tulley called out for assistance and he said D1527 was attempting to strangle himself in his room. DCO Fraser was present and he

explained during his interview that he initially held D1527 's legs while DCO Tulley stopped D1527 strangling himself.

7.35. Panorama captured DCO Paschali and DCO Francis entering the room answering the verbal call for assistance. CCTV confirmed these were the only officers present, other than Nurse Buss who was seen at the door. DCO Fraser stated during his interview that DCO Paschali took control of D1527 's head so he moved to the door and his use of force on D1527 ended. Panorama footage later showed DCO Francis at the door and therefore whilst his explanation of his initial restraint of D1527 legs and how he was able to call for assistance was unclear, his account that he moved to the door and was not involved further in the use of force seemed correct.

7.36. DCO Tulley held D1527 's left arm and DCO Francis held his right arm while DCO Paschali was shown on Panorama for a second or two to have his hands and fingers around D1527 's neck. The footage then showed DCO Paschali with D1527 's head between his knees and DCO Paschali's hands on his knees, i.e. not touching D1527 s head or neck. D1527 then appeared to struggle and DCO Paschali leant over D1527 and in a low voice said *''don't fucking move you fucking piece of shit. I'm going to put you to fucking sleep''* he was then shown with his hands around D1527 's neck and he appeared to digging his fingers in, while D1527 made gasping noises as if he was struggling for breath. The other two officers continued to hold his arms. Panorama showed that DCO Tulley told DCO Paschali to *'take it easy'*. DCO Francis stated at his interview that he nudged DCO Paschali as he thought DCO Paschali's actions were potentially illegal. DCO Fraser maintained that he could not see this restraint as the officers' bodies blocked his view.

7.37. DCO Paschali stated that he did not threaten to kill D1527 and that he had actually said *''don't move you fucking piece of shit I don't want to put you to sleep'',* but Panorama wrote in the subtitles *''I'm going to put you to sleep''* to misrepresent him. This is not correct and DCO Paschali was misleading in this evidence. DCO Paschali explained that he said these words to shock D1527 D1527 into complying with him and he believed he succeeded.

7.38. DCO Paschali stated that whilst he was not using a C&R technique, he did not choke D1527 as alleged on the programme and that he was supporting D1527 D1527 neck to prevent his from swallowing a phone battery and he believed he saved D1527 's life. DCO Paschali stated that he was calm and that his arms were still and he was not throttling D1527 as suggested on the Panorama programme. He did not accept D1527 had difficulty breathing, even though this appeared to be the case on the Panorama programme. DCO Paschali considered he was in control of the situation and DCO Tulley overreacted. He stated D1527 was shouting and screaming and he believed his actions were justified in the circumstances.

7.39. Nurse Buss stated at her G4S investigation interview that she did not recall the incident. CCTV showed that at the time of this incident she was in the doorway of the room and that at times she walked away on to the wing. Whether Nurse Buss and DCO Fraser saw DCO Paschali's actions was not proven, but the two

officers holding D1527 arms both considered at the time DCO Paschali had gone too far. DCO Tulley stated on Panorama he thought DCO Paschali would kill D1527. DCO Francis acknowledged D1527 was in a horrible position and he nudged DCO Paschali as he was concerned DCO Paschali had gone too far and his actions could be close to illegal, which is why he did not write a Use Of Force Report. Detention Centre Rules place on obligation on both officers to inform the manager and the Secretary of State promptly of any abuse or impropriety which comes to his knowledge; they did not.

7.40. The Detention Centre Rules 2001, Rule 41 states; (1) A detainee custody officer dealing with a detained person shall not use force unnecessarily and, when the application of force to a detained person is necessary, no more force than is necessary shall be used. (2) No officer shall act deliberately in a manner calculated to provoke a detained person.

7.41. DCOs are allowed to use proportionate force against a detainee and are trained in approved C&R techniques to do this. Force may be used to prevent a detainee self-harming and it was reasonable for DCO Tulley and DCO Fraser to intervene initially to prevent D1527 from strangling himself. However the actions of DCO Paschali did not appear to be proportionate to meet the criteria of Rule 41.

7.42. Jon Collier, the Head of Centre at the National Tactical Response Group (NTRG) of HM Prison & Probation Service, reviewed the Panorama footage and stated that officers are told in the C&R training never to hold a detainee by the neck. He confirmed DCO Paschali's actions are not in accordance with any approved technique and there did not appear to be any justification for the level and type of force he used against D1527.

7.43. Following any use of force, officers must de-escalate the incident as quickly as possible. The Panorama footage showed DCO Francis saying to D1527 who was making a lot of noise, *''are you a man or a mouse?''* and *''stop being a baby''.* DCO Francis explained during his G4S investigation interview that his words may have sounded harsh but he was attempting to get D1527 to come back to reality. A similar explanation to that given by DCO Paschali for his threats. The Panorama programme did not show any sympathetic words spoken to D1527 during the entire restraint, although it was accepted that the whole scene was not broadcast. Panorama showed officers moving D1527 D1527 to the recovery position before leaving the room, which DCO Francis stated was usual. DCO Fraser's on-going observations recorded that once the officers had left the room D1527 was left on the floor of his room and he remained there for two minutes, face down.

7.44. D1527 alleged that the battery was forcibly taken out of his mouth. This was not captured on the Panorama programme and no further detail was provided to state which officer was alleged to have done this. It would have been an inappropriate use of force and DCO Paschali stated that he did not wish to put his fingers inside D1527 's mouth to remove the battery as he might be bitten. Nurse Buss did state on her medical records that D1527 removed the battery himself.

7.45. **Conclusion**

7.46. DCO Paschali's did not acknowledge that his actions were wrong and his account of events was shown to be untruthful; therefore, there was no credibility to his explanations.

7.47. DCO Paschali threatened to 'put D1527 to sleep' while he used non approved restraint techniques on D1527 and appeared to dig his fingers into D1527 neck while D1527 struggled to breath, while he was held by two other officers. This was not in accordance with any Home Office policy of procedure. Therefore, on balance, the allegation that DCO Paschali assaulted and threatened D1527 was substantiated. There is an ongoing police investigation to consider whether his actions were criminal.

7.48. DCO Tulley and DCO Francis were aware of the actions of DCO Paschali as they happened. They did not intervene and assist D1527 even though they both later stated DCO Paschali's actions were life threatening. These officers also failed to comply with their obligations under Detention Centre Rules to report the abuse to their managers and the Home Office.

7.49. **Allegation**

7.50. **To investigate allegations Officer Yan Paschali directed the nurse not to write up the incident and officers talking about the incident in a derogatory fashion afterwards.**

7.51. **Review**

7.52. Panorama showed footage following this use of force of DCO Tulley following DCO Paschali into an office.

DCO Tulley -*yeah sorry Yan mate you know what I'm like with C&R*,
DCO Paschali- *No, no listen that was proper C&R really, don't worry about it…as it stands no use of force. That's your answer as it stands.*
DCO Tulley - *No use of force?*
DCO Paschali - *just hold fire*.

7.53. This conversation suggested that DCO Tulley had asked DCO Paschali if they were to write Use Of Force Reports although such a conversation was not broadcast. However DCO Paschali's response appeared to encourage DCO Tulley not to complete a Use Of Force Report. The decision on whether a report was required by the officers was not DCO Paschali's and each officer who used force was responsible for their own report. As the initial intervening officer DCO Tulley should have written an Incident Report and immediately reported the incident and passed his report to the duty manager, Oscar 1. Therefore DCO Paschali is not solely responsible for the lack of documentation.

7.54. Panorama next showed Nurse Buss talking DCO Tulley:

Nurse Buss-*Are they putting that down as a restraint?*
DCO Tulley -*I think as it stands, according to what Yan has just told me, they are just going to leave it.*
Nurse Buss -*T-shirt around his neck angry and upset, battery in his mouth, attempted to self strangulate in the toilet. Continued observations due to demeanour. Yeah that's all I can say isn't it.*
DCO Tulley then stated on camera that Nurse Buss was reading from her notes and did not mention the restraint even though she had been in the room when it happened.

7.55. The ACDT on-going records showed an entry at 19:40 hours written by Nurse Buss '**D1527** *had a T-shirt around his neck and was angry and upset had a mobile phone battery in his mouth attempted to self strangulate in the toilet . Usual observations only due to demeanour'*. The exact comment she read out on Panorama. However, it was DCO Tulley who was shown advising Nurse Buss that the officers were '*going to leave it'* not DCO Paschali.

7.56. Healthcare staff must complete form F213 when they attend an incident and this form was completed by nurse M Makum on behalf of Nurse Buss. It stated '*detainee had placed a ligature around his neck, removed by staff. After that he went to toilet and attempted to self strangulate- hands removed from his neck. Slight redness noted on his neck'*. On Panorama DCO Tulley stated that **D1527** **D1527** was attempting to strangle himself with his own hands just before he was restrained by DCO Paschali and therefore this second comment on the F213 appeared to refer to this incident. Therefore the incident was documented by healthcare on both on the F213 and in the ACDT on-going records, but there was no reference to the use of force by the DCOs and the wording was vague so that it was not possible for anyone to determine the severity of these incidents.

7.57. Detention Centre Rules 41 states that following the use of force the particulars of every case of use of force shall be recorded by the manager in a manner to be directed by the Secretary of State, and shall be reported to the Secretary of State.

7.58. G4S have a flow chart for officers setting out what reports are required following an incident which leads to the use of force against a detainee. This states the first intervening officer must write an Incident Report and every officer who witnessed the incident must write a witness statement. If force was used then the all officers using force are required to complete an Annex A Use of Force Report.

7.59. CCTV and Panorama showed that DCO Tulley was the intervening officer and he should have completed an Incident Report and a Use of Force Report. DCO Francis, DCO Paschali and DCO Fraser should have completed an Annex A, Use of Force Reports. DCO Paschali stated in his evidence that he did not discuss the writing reports with anyone other than DCO Tulley who kept asking him whether to write a report. DCO Paschali maintained that he did complete an Incident Report, which he left in the E Wing office and he believed DCO Tulley then disposed of it. However DCO Paschali's evidence was not considered a

truthful account of what happened and no Incident Reports or Use Of Force report written by DCO Paschali or any other officer was identified.

7.60. DCO Fraser and DCO Francis were asked why they did not complete Use Of Force Reports during their interview with G4S. Neither officer provided a satisfactory answer, although they both agreed they should have. Both stated there was no collusion and they were not told by DCO Paschali not to complete the report. Immediately following the incident two managers, DCM Dix and DCM Yates came to D1527 room to check his ACDT. Not one of the four DCOs informed them of the use of force that had just occurred, even though this usual procedure and it would be a natural reaction to talk about a stressful incident immediately afterwards as a reaction to the adrenalin and stress. Instead they all appeared to have remained silent and therefore it seemed more likely than not that there was some consensus that the event was not disclosed, although the motivation for each officer was not known.

7.61. Once an Incident Report is submitted the duty manager will ensure each officer completes a Use Of Force Report and the Duty Manager will notify the Home Office and other relevant authorities of the incident. The lack of an Incident Report and associated documentation meant that there was no G4S or Home Office oversight, no self-harm investigation and no immediate ACDT case review of D1527 's risk as he was held in isolation on Rule 40 at the time.

7.62. **Conclusion**

7.63. There was evidence of the conversation between DCO Tulley and DCO Paschali in which DCO Paschali suggested to DCO Tulley that no use of force report was to be completed. The other officers deny there was any agreement not to write a Use Of Force Report, but it seemed more than a coincidence that DCO Francis and DCO Fraser would both decide in isolation not to write a Use Of Force Report against policy. All officers therefore failed to comply the Detention Centre Rules.

7.64. It was DCO Tulley, not DCO Paschali, who advised Nurse Buss not to refer to the restraint and he did not correct her or ask her to add include the restraint in her records when she read this to him. That is not to say that Nurse Buss had to oblige. She did record the two incidents of self-harm on 25 April 2017, although her records were vague and it appeared this was done with the intention not to raise attention to the restraint used on D1527

7.65. Therefore, it was considered, on the balance of probabilities, that there was collusion by the G4S staff not to record the events in accordance with policy and procedure, and therefore the allegation is substantiated.

7.66. **Allegation**

7.67. Following this incident there were further conversations between the officers which were derogatory.

7.68. Panorama showed DCO Paschali with officers in what appeared to be a staff

rest room

DCO Paschali- It difficult to explain, Callum had a taste and got a bit upset ,
DCO Tulley-I didn't get upset, (laughs)
DCO Paschali-I didn't say you cried, but the likes of us we don 't cringe at breaking bones…

7.69. DCO Paschali suggested he did not care about hurting a detainee. CCTV did suggest that DCO Tulley was upset by DCO Paschali's use of force and Panorama showed DCO Tulley was very upset by what had happened. DCO Paschali and other officers discussed at various times during the Panorama programme the use of force and that they did not care about the detainees. This was not related to D1527 but they did suggest that there was a culture issue with some officers, as alluded to by DCO Sanders.

7.70. On 4 May 2017 when D1527 was shown on Panorama protesting on the netting DCO Tulley was with DCO Fraser. DCO Tulley asked DCO Fraser *"What is the best way to deal with someone like that?"* DCO Fraser responded *"Like Yan did"* and he laughed.

7.71. DCO Fraser stated that he did not see DCO Paschali's restraint of D1527 on 25 April 2017 but his comment suggested otherwise. DCO Fraser explained that DCO Tulley had told him about what DCO Paschali did in subsequent conversations about the incident.

7.72. DCO Tulley instigated the comment and DCO Fraser stated that they had become easy in each other's company following the incident on 25 April 2017 due to DCO Tulley seeking him out for discussions. However DCO Fraser's response to DCO Tulley when he suggested that choking D1527 was an appropriate response was unprofessional and it may be considered derogatory.

7.73. **Conclusion**

7.74. Officers comments made following the use of force appeared on balance, to be derogatory towards D1527 and the allegation is substantiated.

7.75. **CONSIDERATION OF THE FURTHER ALLEGATIONS MADE BY D1527 D1527**

7.76. **Allegation**

7.77. **D1527 stated that on 4 May 2017 he was assaulted in his room by officers before he was moved to Rule 40.**

7.78. **Review**

7.79. In evidence submitted by his solicitor, D1527 explained to Dr Basu that on 4 May 2017 a canteen worker refused to give D1527 a plate at mealtime as she claimed he had already eaten. When a plate was finally given to D1527 he broke it, took a shard of the broken plastic and jumped onto the netting. He

was talked down by two detainees and he went into their room. Following this around six guards rushed the room when excessive force was used and he was dragged forcibly to E Wing.

7.80. This related to the incident shown on Panorama when D1527 was shown protesting on the netting and asking to be left alone.

7.81. Incident Report 325/17 was completed by DCM Dix in relation to this issue. He and the officers completed Use Of Force Reports and their accounts were supported by the CCTV footage and the body worn camera (BWC) footage. The officers' evidence reported that D1527 jumped onto D Wing netting and refused to leave. Two fellow detainees spoke to him and D1527 agreed to leave the netting if there were no staff present. Later DCM Dix and DCM Yates went to speak to D1527 in a room. CCTV showed that they entered D1527 D1527 room at 17:15 hours. DCM Dix explained to D1527 that he had to go to CSU on Rule 40, but D1527 refused. D1527 put his hands in his pocket and DCM Dix asked him to remove them but D1527 refused. DCM Yates recalled D1527 stating "you'll see what's in my pocket" then he stood up with clenched fists and started shouting. DCO Bromley and DCO Shaukat were alerted to the increased disruption and they entered the room at 17:23 hours (as shown on the CCTV). This was as DCM Dix spontaneously took control of D1527 right arm, before he passed control to DCM Yates. DCO Bromley took control of D1527 left arm and DCO Shaukat controlled D1527 D1527 head. DCM Dix then placed D1527 in handcuffs and DCO Shaukat released D1527 head. CCTV showed they left the room at 12:25 hours and walked to E Wing.

7.82. DCM Yates noted that D1527 became more disruptive as they left the wing and he used pain compliance to get 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 D1527 through the door. When D1527 was escorted through the door DCO Shaukat had taken control of D1527 head. Once in the corridor DCO Shaukat released this hold and D1527 was held by the arms by DCM Yates and DCO Bromley as they walked through the medical corridor and in the activity corridor. D1527 appeared to be resisting and shouting at the officers.

7.83. CCTV showed that when they reached the stairs there was a long conversation between DCM Dix and D1527 during which D1527 kept moving his head towards DCM Yates who was controlling his right arm. At this point a manager arrives wearing a BWC and his footage captured the conversation, although D1527 complaint was inaudible. DCM Dix took control of D1527 D1527 right arm and D1527 was then compliant and walked with officers to E Wing without further struggle.

7.84. The BWC footage captured staff behaving professionally towards D1527 and explaining what was happening. The footage continued until they arrive at E Wing and D1527 was informed a full search would be carried out. The BWC footage then ends. CCTV footage showed the manager wearing the BWC

left the incident and less than a minute later DCM Yates ran to him and took the BWC and returned to the room where D1527 was detained. A second BWC recording then began and officers stated DCM Dix wanted audio of the full search which was taking place. The camera was pointed away for decency reasons but the BWC footage captured DCM Dix talking to D1527 but there was no shouting or complaint by D1527 in response. DCM Dix stated that they would now observe D1527 but he must not self-harm and he must stay calm until the morning. He stated that he had earlier explained to D1527 that he should have discussed his issue with a manager and not jumped on the netting and that was what got him into trouble and that he went from being ok, to going too far too quickly. D1527 did not respond.

7.85. DCM Dix was then heard to explain to D1527 that he had to wear sterile clothing, which D1527 objected to. There was then a discussion outside the room regarding whether sterile clothes were necessary and the recording ended abruptly. CCTV showed that officers continued to wait outside the room and were chatting and there was no indication there was any further incident.

7.86. CCTV footage confirmed neither DCM Yates nor DCM Dix wore a body worn camera. In April 2017, the use of BWCs was not obligatory and there were not enough cameras for all managers to have them. Given D1527 had been on the netting it would have been useful for a handheld camera, or a BWC to have been used from that point to capture the full incident and the audio. Something that is vital to assist in establishing facts. CCTV showed the BWC footage started when a manager wearing a BWC arrived at the scene and immediately turned it on. The recording ended abruptly which was against the BWC policy at the time, as managers were required to record incidents in full until resolution. The footage that existed showed that DCM Dix was professional and polite and explained to D1527 what was happening. The CCTV footage did not show anything of concern to suggest the BWC footage was stopped deliberately to conceal any mistreatment of D1527 and it was considered the unsatisfactory recordings were most likely to be due to the managers not following the policy.

7.87. DCM Dix completed an IS91 RA Part C to report D1527 was relocated and placed on Rule 40. This stated that he spoke to D1527 about the consequences of his behaviour and going on the netting and D1527 reaction caused concern and due to his history of self harm he was relocated to Eden wing by force. And placed on constant observation. DCM Dix completed a DCF1 Rule 40. An ACDT case review was held that night and the record stated D1527 '*apologised for jumping onto the netting but did not give a reason and said it would not happen again and he understood why force was used and why he was placed on Rule 40. The observations were reduced to hourly'*.

7.88. D1527 s complaint related to the use of force in his room when he alleged six guards rushed in and assaulted him. CCTV showed DCM Dix spoke to D1527 D1527 for nine minutes trying to persuade him to move to E Wing, before the use of force began. The initial use of force was not is was not captured on camera, although CCTV confirmed five officers were present as the use of force

started, and there were more officers were present as the journey to E Wing. The officers' accounts of the use of force and the subsequent journey to E Wing were supported by the camera footage. There initial force was used as DCM Dix was concerned D1527 was going to take something out of his pocket and DCM Yates believed D1527 made a threat. Given that D1527 had self-harmed on a number of occasions both DCMs were aware of his high risk and therefore it was considered that the action to use force appeared necessary and justified in the circumstances. It was noted that when D1527 left his room, DCO Shaukat did not control his head and when D1527 became disruptive as they left the wing, DCO Shaukat took control again, but released his hold soon after. This was proportionate to the level of resistance D1527 showed. Furthermore when D1527 complained about DCM Yates, rather than insisting DCM Yates continued to control D1527 arm, DCM Dix pragmatically swapped places. DCM Yates recorded his use of pain control and CCTV supported his account of the level of disruption at that time. There was no evidence that excessive force was used, or that staff were unprofessional during the use of force.

7.89. **Conclusion**

7.90. There was no evidence that staff used excessive force against D1527 on 4 May 2017 and the allegation was, on the balance of probabilities, unsubstantiated.

7.91. **Allegation**

7.92. **That's staff discriminated against D1527 because of his religion and criminal record.**

7.93. **Review**

7.94. D1527 alleged that he experienced racism at times from IRC staff, including, he said, a guard who had said to him aggressively "*what do you need to go to the fxxxing* Sensitive/Irrelevant *for?*" when he had asked for leave from E-Wing to attend Sensitive/Irrelevant No further details were provided and therefore it was not possible to identify the officer who allegedly stated this. D1527 on-going observations showed that he was taken to Sensitive/Irrelevant whilst on constant supervision and was provided with Sensitive/Irrelevant when he moved to E Wing. It was therefore not possible to establish if such a comment was made from the detail provided, but overall there was evidence D1527 was provided with the opportunity to practice his religion.

7.95. D1527 said that he has also experienced other IRC guards threatening to deport him, swearing at and/or disrespecting him or his religion. His view is that this does not occur to other detainees as much as him, from his own observations and he considers that this may be due to IRC officers coming to conclusions about him based on his case file, particularly assuming that he is a sexual offender. This allegation appeared to be a general allegation without any officers being named.

7.96. Some details of D1527 criminal record were recorded on his records and G4S officers have access to these computer records as needed. DCO Tulley secretly filmed several incidents with staff interacting with D1527 DCO Sanders conducting the constant supervision; DCO Loughton intervening when D1527 attempted to use a ligature then swallow a battery; DCM Ring commenting on D1527 sucking on the battery; the use of force by DCO Paschali and the incident when D1527 was on the netting. During these interactions the officers called him *'a prick', 'attention seeking', 'an arse' and a 'baby'*, but there was no reference to D1527 criminal record or his religion. Panorama did show one officer using racist language but there was very little comments shown on the programme to suggest this was widespread or aimed at D1527

7.97. **Conclusion**

7.98. There was no evidence to substantiate the allegation that D1527 suffered discrimination by staff due to his religion or criminal record and on the balance of probabilities, the allegation was not substantiated.

7.99. **To investigate whether Brook House IRC officers failed to ensure provision of medical healthcare.**

Allegation

7.100. The adequacy of D1527 's medical healthcare is outside of the remit of this investigation. However it was found that there was some issues regarding the access to medication that are worthy of note.

7.101. **Review**

7.102. D1527 arrived at Brook House IRC on 4 April 2017 from HMP Belmarsh. The Reception Induction Record completed by the reception officer failed to note that D1527 had an open ACDT or any medical issues yet D1527 had arrived without his prescription medication for depression. However D1527 D1527 was met by G4S managers who explained his care plan to him, reviewed his ACDT and completed an IS91RA to advise DEPMU of D1527 's open ACDT. D1527 also saw a nurse and an appointment was made for him to see the GP in line with procedure and the Registered Mental Health Nurse (RMN). D1527 medical notes showed that he saw a GP the following day and his anti-depression medication was prescribed. Detainees are risk assessed regarding how their medication will be dispensed and D1527 was advised he should collect his medication at 13:30 hours daily.

7.103. On 7 April 2017 during an ACDT review D1527 stated that he was not good and that he needed medication for his neck and he had not had his anti-depressant medication *'lately'*. The nurse advised the anti-biotics for his neck would arrive on 8 April 2017 as the doctor had completed the prescription that day, his anti-depressant medication was now in stock and he needed to collect it at lunchtime each day. D1527 stated he was '*sometimes struggling with anxiety attacks'* and he was reminded he had an appointment on 12 April 2017

with the RMN. D1527 stated that he had occasional thoughts of self harm but he agreed he would approach staff. His level of ACDT care was to remain the same and the following day it was reduced as staff had witnessed his general good mood.

7.104. However during the night of 8 April 2017 D1527 came to the attention of staff and he explained he had a lot going on in his head and he had not had his medication for five days. D1527 had self harmed and made superficial cuts to his wrists. An ACDT review was carried out and his risk was raised. However D1527 had informed staff earlier that day he was struggling to cope and he had not had his medication for four days, yet there did not appear to be any intervention by staff to ensure D1527 received his medication at the earliest opportunity.

7.105. On 9 April 2017 another emergency ACDT case review took place at 17:00 hours which recorded that D1527 had not collected his medication at 13:30 hours. At 16:05 hours D1527 asked for his medication at the wing office and the report stated the officer could not get through to healthcare so D1527 threw a chair down the wing in frustration and returned to his room and cut himself with a razor blade. He returned to the wing office to request a plaster and was taken to healthcare. D1527 collected his medication at 19:40 hours. Records suggested this was the first time D1527 had his medication since his arrival at Brook House IRC, five days earlier. Whilst D1527 had been informed when to collect his medication he was not, and he was reporting to staff the adverse effect not taking his medication, yet there did not appear to be any support or intervention in place by officers to ensure D1527 collected and took his anti-depressant medication daily.

7.106. On 17 April 2017 an emergency case review was held after healthcare raised concerns about D1527 DCM Aldis went to D1527 's room and D1527 D1527 stated he was having problems sleeping and he had not taken his medication the previous day. And at 21:00 hours the on-going records described D1527 was agitated as he had not had his medication for three days. D1527 later told staff he had self-harmed earlier that day and he had superficial cuts on his left upper arm.

7.107. On 21 April 2017 D1527 was reported again to be in a low mood and that he was not taking his medication regularly as he forgot. G4S officers were concerned D1527 was unwell and they called healthcare over to his room to examine him, demonstrating their duty of care. D1527 later told the RMN that he would hang himself but would not explain why. D1527 collected his medication from healthcare that night.

7.108. There appeared to be a pattern that D1527 was reporting to staff he was not feeling well and that he was missing his medication and he would then self-harm. Once he had his medication the records appeared to show there was an improvement in his mood, yet this pattern was not noted. He had many ACDT reviews but this was not addressed.

7.109. **Conclusion**

7.110. Detainees are given as much responsibility for their own decisions as possible. This would include collecting their medication. The regular ACDT reviews ensured D1527 was monitored and there were occasions when D1527 's medical appointments were moved around when he reported issues over timing. However, he was on antidepressants and he did report to officers that he was not taking his medication and subsequent to that he self-harmed. Whilst D1527 was not prevented from receiving healthcare, there may be a lesson to be learned regarding access to medication and detainees who require extra support.

7.111. **Allegation**

7.112. A separate concern was raised by D1527 's solicitor. They complained that the use of force on D1527 on 25 April 2017 was not properly documented and therefore when he saw the doctor the following day the appropriate support was not offered. This related to the effects of the trauma D1527 suffered, rather than the self-harm.

7.113. **Review**

7.114. As already discussed, the F213 for 25 April 2017 did reference two attempts by D1527 to self-harm, but it did not refer to the use of force for either incident, even though the first incident was properly documented. Medical records showed that both the self harm incidents were recorded and that for the second incident '*he went to toilet to self strangulate, angry and not engaging with staff, hands removed from his neck by staff, slight redness noted on his neck'*. A later record that night showed D1527 requested sleeping tablets but his prescription had run out but the nurse '*observed redness mark on both sides neck but skin intact'.* Whilst an Incident Report and the Use of Force Reports were not prepared for the second restraint, these would not have been routinely reviewed by the doctor examining D1527 . In addition D1527 could have raised the use of force with the doctor had he felt traumatised, therefore there was no evidence that the non completion of the reports related to the second incident undermined the medical examination.

7.115. **Conclusion**

7.116. There was no evidence to support the lack of reports by G4S staff on 25 April 2017 led to D1527 not receiving appropriate medical care.

7.117. **Allegation**

7.118. D1527 's solicitor alleged he was repeatedly removed from association, put into segregation, and repeatedly locked in his room, which was as an unacceptable means of managing his mental illness and/or as punishment for his disturbed behaviour.

7.119. **Review**

7.120. Records showed that D1527 was placed on Rule 40 twice while detained at Brook House IRC. The first occasion was on 25 May 2017 at 17:10 hours 'to maintain good order and discipline in the centre' as he was refusing to return to Eden wing under constant supervision'. The on-going observation records showed that D1527 was becoming non-complaint for the hours immediately before he was placed on Rule 40 and therefore this decision may have been appropriate. However, ACDT guidance contained in DSO 6/2008 states that at risk detainees should not normally be isolated and should remain in association wherever possible. There were no records identified to show there were discussions with D1527 regarding his non-compliance and therefore it was unclear what de-escalation process took place prior to the decision to place him on Rule 40. As D1527 was on constant supervision, he remained in a safer community room on E Wing, rather than moved to the Care and Separation Unit (CSU). However he was not placed on Rule 40 to manage his mental illness or as punishment for his disturbed behaviour, the records showed he was non compliant.

7.121. Nurse Buss completed a Removal from Association Initial Health Assessment and concluded D1527 would not be adversely affected by being placed on Rule 40. The Rule 40 paperwork was issued to notify the Home Office and IMB, although no records were identified which confirmed when D1527 was served with a notice to inform him of the decision and reason why he was placed on Rule 40. The on-going records showed that DCO Fraser informed D1527 D1527 he was on Rule 40 when D1527 asked why he was not being allowed out of his room following the unlock from roll count. D1527 reacted badly to this and less than fourteen minutes later he self harmed by attempting to strangle himself with a ligature, subsequent to this he put a battery in his mouth and attempted to strangle himself as documented already. Therefore the Removal from Association Initial Health Assessment appeared to have been incorrect.

7.122. D1527 was placed on Rule 40 a second time when he jumped onto the netting on 4 May 2017 as a protest. Again he was not placed on Rule 40 to manage his mental illness or as punishment for his disturbed behaviour, but because he went onto the netting in protest which was not permitted and dangerous behaviour. The circumstances surrounding this incident are discussed earlier in the report. An assessment of Association Initial Health Assessment was carried out and no issues were identified, and D1527 was served with his notification.

7.123. On both occasions, D1527 was placed on Rule 40 overnight.

7.124. D1527 was placed on constant supervision several times during his detention at Brook House IRC. This was always in reaction to the risk D1527 D1527 presented and there was evidence to show D1527 's risk of self-harm was monitored and his observations by staff were adjusted in accordance with the risks he was considered to present at that time..

7.125. **Conclusion**

7.126. D1527 was vulnerable and considered a person at risk, he was placed on Rule 40 twice and removed from association due to his non-complaint behaviour. This is documented and it was not to manage his mental illness. The allegation is therefore not substantiated.

8. WIDER ISSUES

8.1. **To consider whether there were any organisational deficiencies which may have contributed to D1527 's treatment, including but not limited to;**

8.2. **The suitability of the complaints process for staff:**

8.3. No officers were identified in the investigation who stated they had raised concerns about any of the officers who Panorama alleged had mistreated D1527 D1527 Staff stated they were aware they could raise complaints about colleagues with their managers, but they had not needed to. The officers had no previous disciplinary records during their employment at Brook House IRC.

8.4. **The suitability of the complaints process for detainees:**

8.5. D1527 's solicitor alleged that D1527 raised issues with healthcare staff, they were not dealt with in accordance with medical standards or relevant procedures. Nobody sought to deal with complaints that were raised nor sought to allow D1527 to access a complaints procedure.

8.6. **Review**

8.7. Detainees are encouraged to raise any complaints with officers on the wing in the first instance. Detainees are advised of the formal complaints procedure during their induction to Brook House IRC. D1527 received his induction on 5 April 2017 on B Wing. There is a complaints box on every wing, which is opened by Home Office staff daily. G4S staff do not have access to the complaints. Complaints are registered by the Home Office and then allocated to the appropriate authority to investigate and provide a response to the complainant. If the complaint related to healthcare this would be passed to NHS England Customer Contact Centre to investigate. There was no record of D1527 D1527 having submitted a complaint, usually on a DCF9, into the complaints box during his stay at Brook House IRC. Had he done so his complaint would have been passed to Healthcare, or other relevant party for an investigation and D1527 D1527 would have been provided with a response. Complaints are monitored by the Home Office to ensure the complainant receives a response in line with DSO 3/2015.

8.8. D1527 solicitor submitted a report from Dr Amlan Busu which explained that D1527 due to his experiences growing up in a family where he could not complain, and an incident in HMP Belmarsh where his complaint was not

investigated, meant that D1527 did not have faith in the complaints system and therefore he did not submit complaints. These factors occurred before he arrived in Brook House IRC but it was offered as the reason why D1527 did not complain at the time of his detention in Brook House IRC.

8.9. D1527 ACDT records and his medical records showed that he had regular contact with medical staff and that G4S staff monitored his welfare on almost a daily basis for his entire detention period at Brook House IRC. He had the opportunity to raise his concerns direct to Healthcare staff had he wished to. At the ACDT review meetings he was asked regularly if he needed anything and he generally said no, although when he did raise issues regarding his medication appointments were made for him to see the GP.

8.10. **Conclusion**

8.11. There is a process in place for detainees to complain about any aspect of their detention, including healthcare. There was no evidence to show that D1527 made a complaint and on balance, this allegation was not substantiated.

8.12. **The training of officers:**

8.13. **Review**

8.14. Officers are trained on ACDT on their initial training a have annual refresher and staff appeared to complete the records appropriately, although there were some improvements to the standard of notes required. Officers were reminded in their training to treat detainees with respect.

8.15. DCO Fraser failed to record any ACDT observations between 19:01 hours and 19:40 hours on 25 April 2017. However, he recorded observations at other points so again this appeared to be due to his intentional cover up, rather than a lack of training. There was no evidence the absence of any comments for 40 minutes was not raised as an issue at the time with DCO Francis.

8.16. The officers involved in the restraint of D1527 by DCO Paschali were all aware that they were required to complete a use of force reports: this was not a failure of training. They were also concerned about the actions of DCO Paschali who was not using approved C&R techniques, this was not a failure in training.

8.17. DCO Sanders was fully aware that to hurt D1527 whilst on a constant watch was not appropriate and this was not a failure in training.

8.18. DCM Ring's comments about D1527 were inappropriate and derogatory, but officers are taught about the values and this was not down to training.

8.19. **Conclusion**

8.20. It appeared that the main failings towards D1527 were due to officers making poor decisions, this appeared to be a lack of their good judgment, not poor training.

8.21. **The supervision of officers:**

8.22. Officers were able to conceal their actions by not reporting it. No managers routinely checked on D1527 during the abuse and the lack of documentation such as DCO Fraser not completing on-going observations was not challenged Without alerting managers incidents can remain concealed if no G4S manager attends the scene unexpectedly. Home Office staff based at Brook House IRC do visit CSU and see the detainees, but their presence in the centre, like the IMB, is limited. The supervision of officers is considered further below.

8.23. **To consider and report on whether there is any learning for any individual G4S staff member, or organisational learning for the Home office or G4S, including whether any change in Home office or G4S policy or policy or practice would help to prevent a recurrence of the incident investigated.**

8.24. There did appear to be an unusual series of events, which enabled the use of force by DCO Paschali to be concealed:

- There were four officers present and a nurse but no one else came to the door during the incident.
- Not one of the officers pressed their emergency button
- Not one of the officers told the managers arriving immediately after the event that any kind of incident had just happened
- Not one of the officers subsequently wrote a report
- The nurse was compliant with the DCOs by not referring to the use of force.
- D1527 did not complain.

8.25. The intervention by DCO Tulley to stop D1527 self-harming and the officers who responded was spontaneous and therefore there was no evidence the concealment of the incident was pre-planned. It was not known why all the officers agreed, but in order for the incident to remain concealed all the officers had to make the same decision not to comment on, or record the incident. D1527 D1527 did not raise a complaint and therefore the undercover footage brought the incidents to light.

8.26. The Incident Report provides officers with clear guidance of what reports are required. Once completed these would have set into play a chain of notifications and case reviews. The earlier use of force by DCM Loughton, the use of force on 24 April 2017 and the use of force on 4 May 2017 showed that the system was in place and followed by staff. However the officers involved need to instigate the process. Detention Centre Rules place on obligation on both officers to inform the manager and the Secretary of State promptly of any abuse or impropriety which comes to his knowledge; they did not.

8.27. CCTV does not capture what happens inside a detainee's room for privacy reasons. On 25 April 2017 CCTV footage showed that officers regularly entered and left E Wing and many looked in D1527 's room. However, CCTV showed that while DCO Paschali restrained D1527 , no other officers went to D1527 's room to witness what occurred, or be aware of the use of force.

8.28. During the incident the officers could have pressed their emergency button on their radio to call the First Response officers and the duty manager to assist at any point. Records confirmed that no officer pressed their individual emergency button.

8.29. However there did appear to be a missed opportunity for questions to have been asked immediately after DCO Paschali's use of force. CCTV showed the Officers left D1527 's room and DCO Tulley appeared to be upset and he left E Wing. DCO Francis also left. Less than a minute later DCM Dix and DCM Yates arrived on E Wing and went to D1527 room. Both DCM Dix and DCM Yates stated that they did not recall what was said and they did not document the conversations on the ACDT on-going records, which DCM Dix agreed he should have done. DCM Paschali and Nurse Buss were seen on CCTV talking to DCM Dix, who then entered D1527 's room with another manager. DCM Dix left shortly afterwards with the other manager, DCM Yates and DCO Paschali. The CCTV showed that at this point Nurse Buss' had yet to write her comments on the ongoing records. DCO Fraser had not completed an observation in the records since 19:01 hours and this was not challenged by any of the managers present.

8.30. It was unfortunate that neither DCM Dix nor DCM Yates recalled what occurred. DCM Dix stated that he had made numerous similar visits. It was possible that if this visit was routine and no issues were raised he would not recall it. The conversation between DCO Tulley and DCO Paschali when they discussed not writing the Use of Force reports must have taken place after DCM Dix spoke to DCO Paschali due to the location of the conversation. Therefore, based on DCO Paschali's advice to DCO Tulley he must have considered the use of force was not known by others and therefore it was likely DCO Paschali had not informed DCM Dix of what had occurred.

8.31. DCO Sanders provided further evidence that the reporting procedure was not always adhered to by officers. He stated that he had to prevent D1527 from hurting himself and he had to remove his hands from his neck and place a pillow under his head. Such physical interventions, in particular preventing his from digging his hands in his neck would require an Incident Report, a Use Of Force report and a record of any injury to D1527 to alert the duty manager to the continuing self-harm. No reports were identified and the vagueness of DCO Sanders comments in his on-going records meant this matter was not followed up by the duty managers reviewing the records.

8.32. DCO Sanders also stated openly that he hurt a detainee to DCO Tulley and DCO Stokes. Detention Centre Rules state that '*an officer shall inform the*

manager and the Secretary of State promptly of any abuse or impropriety which comes to his knowledge'. Therefore there is an obligation on these DCOs to report such statements of abuse, but this did not happen.

8.33. Therefore, it would appear that the policy and procedures are in place to record and report the use of force, acts of self-harm, and staff abuse, but these staff did not always follow this. I will make no comment on motivations or reasoning whilst certain matters remain under criminal investigation. The IRC was a busy place with staff moving around the centre continually, but there were times when officers were not supervised and therefore if they carried out single acts of abuse, this may remain hidden if the detainee does not complain. Similarly if a group of officers all chose not to report an incident it was shown it was possible to conceal this, if all the officers involved agree. Since Panorama, G4S have introduced new BWC equipment and a new policy, which is currently being rolled out. This requires all DCMs and all DCOs to wear BWC and to record any incident from beginning to end. The non-use of a BWC will be challenged and the footage will be randomly reviewed to ensure staff behave appropriately. This did not happen at the time D1527 was detained at Brook House IRC. If the officers attended an incident such as the one involving DCO Paschali's restraint on 25 April 2017 they would now also have the added factor that no officer had turned on their BWC, in addition to the other factors.

8.34. **Conclusion**

8.35. There are policies and procedures in place to ensure the welfare of detainees and that the Detention Centre Rules are complied with. However the officers in these instances have circumvented the policies and procedures and not carried out the necessary reporting. It would therefore appear that the individual officers failed to take appropriate steps when carrying out their duties, rather than there not being a system in place which when followed ensures the duty of care to the detainee and the appropriate notification to the Home Office. Beyond this, measures concerning BWC are to be implemented and, compliance must be monitored. With respect to the officers: Paschali is subject to criminal proceedings and the others were dismissed from their employment at brook House IRC.

8.36. **To consider and report on whether the incident highlights any good practice that should be disseminated.**

8.37. Whilst not worthy of dissemination, D1527 's records were unusually detailed, and many of the records showed that many officers took action to assist D1527 during his detention at Brook House IRC.

8.38. **To consider and report on whether any disciplinary offence may have been committed by any G4S staff member involved in the incident, and whether relevant local and national policies/guidelines were complied with.**

8.39. The officers whose conduct fell below the standards expected are no longer employed at Brook House IRC.

9. RECOMMENDATIONS

9.1. **G4S Policy and Procedure- Rule 40**

9.2. The records did show there appeared to be factor, which may have exacerbated D1527 's frustrations and self-harm. During the night of 23 April 2017, D1527 agreed to move to E Wing as he had self-harmed. The following evening, D1527 complained that the television in his room did not work and he was moved to another room but this television did not work. The observations showed that he was upset through the night.

9.3. During the afternoon of 25 April 2017 records showed D1527 became more resistant to officers, refusing to leave the courtyard, refusing to leave Healthcare and to go to his room for lock up. He was therefore placed on Rule 40 and removed from association. D1527 almost immediately self harmed. Panorama captured D1527 words immediately after DCM Loughton cut his ligature. D1527 was shouting that he 'had asked nicely for a television but he was told no', he appeared upset, angry and frustrated that no one would help him.

9.4. D1527 explained to an officer on 26 April 2017 that watching television in the IRC had become very important to him as it was a distraction, as he could not sleep. Detainees are locked in their rooms from 21:00 hours until 08:00 hours each night.

9.5. D1527 was considered a vulnerable person at risk of self-harm and he was locked in a room with nothing to do. He was on a constant observation and these records showed that D1527 was looking for something to do to occupy his time and he tried to climb the wall and was pacing around the room.

9.6. Detainees placed on Rule 40 at Brook House IRC are not allowed a television and their rooms, the rooms in CSU have no television aerials. D1527 was held in a safer custody room, as he was on constant supervision and on an ACDT. Televisions in these rooms are removable due to the multiple uses for the room. DCM Loughton explained that it might be appropriate to remove a television from a room for other reasons, such as when a detainee has a history of hanging or using ligatures. Whilst it seemed reasonable to remove a television following a risk assessment in these circumstances, detainees have no means of distraction on Rule 40, other their mobile phones.

9.7. This is not the same at other IRCs across the detention estate.

9.8. **ACTION POINT 1**

9.9. It is therefore recommended that G4S consider whether televisions should be made available to detainees on Rule 40, and in particular,

when the detainee is vulnerable.

9.10. **Home Office- Policy and Procedure- Complaints**

9.11. The Home Office currently relies, in most cases, on detainees making a complaint about their treatment before an investigation occurs. The detainees featured in Panorama did not make a complaint about their treatment. Examination of the complaints suggested that many detainees have discussed their complaint with an officer before they submit a formal complaint. It is therefore possible detainees are complaining, just not formally and therefore scrutiny by the Home Office is missed. It is not known why detainees do not formally complain and this may require further investigation with the detainees themselves.

9.12. HO staff visit detainees in CSU daily, many of these detainees will have had force used against them, or they will have issues generally with the regime at Brook House IRC which has led them to be in CSU. It is recommended that the Home Office visits be used as an opportunity to talk to detainees, if they are willing to engage, to ensure failures by G4S are not missed and that allegations of unprofessional conduct are addressed.

9.13. **ACTION POINT 2**

9.14. Detention and Escorting Services should consider discussing the complaints process with detainees to establish whether there are any barriers to detainees submitting formal complaints.

9.15. Home Office staff based in IRCs should ensure that during their contact with detainees any serious allegations and complaints are identified.

9.16. **Home Office- Local Procedures and Supervision**

9.17. G4S introduced new BWC equipment in October 2017 and are currently rolling this out to all officers and managers. They have introduced a new policy which means staff must use the BWCs and they will be challenged if they do not. There will be random reviews of the footage by G4S security. It is recommended that Home Office contract monitoring staff based at Brook House IRC also conduct random checks on the BWC footage to ensure staff are acting in accordance with G4S and Home Office values.

9.18. On average force against a detainee takes place at Brook House IRC once a day. Home Office staff should consider, following a risk assessment, whether to attend all planned use of force. Home Office staff should also examine all the use of force BWC footage of detainees and ensure G4S staff are acting appropriately.

9.19. **ACTION POINT 3**

9.20. Home Office staff at Brook House IRC should monitor the BWC footage,

and observe incidents and planned use of force.

9.21. **G4S- Training- ACDT records**

9.22. The ACDT records of D1527 were extensive. They were mostly legible, however they were incomplete and not in any chronological order. James Begg, G4S audited the records once the ACDT was closed and he made some observations on improvements.

9.23. This investigation found that the use of force on D1527 was not recorded in the observations, and that lengthy gaps in constant observations were not challenged by managers. DCO Sanders made comments on 24 April 2017 which suggested D1527 was hurting himself, but this did not generate any follow up questions. Whilst the ACDT records showed that G4S staff spent considerable time monitoring D1527 the observations also provided further information and opportunities to challenge officers about what had occurred when the written information was too vague, incomplete or missing.

9.24. **ACTION POINT 4**

9.25. It is recommended that the managers are reminded to ensure officers conducting observations complete records which are clear and legible and that they challenge any vague, or missing information.

9.26. All use of force must be recorded.

9.27. Records should be retained in a manner which enables them to be reviewed.

9.28. **G4S Policy and Procedure - Reports**

9.29. D1527 was moved to E-Wing on the night of 23 April 2017 and on 4 May 2017. Many documents were generated by the DCMs, all for different reasons and whilst all documents have a purpose, much of the information was the same in each document. Some documents were completed for one incident, but not completed for others. This was not considered DCMs not doing their job properly, but it was most likely because of the burden of the numerous pieces of paperwork.

9.30. It is recommended that G4S consider creating the documents electronically to enable the managers to access all the documents they require.

9.31. If this is not practical, then it is recommended that G4S review the number of documents managers need to complete and find a way to make it easier for them to access and complete all of the reports required.

9.32. **ACTION POINT 5**

9.33. G4S to review their reports procedures.

Annexes

A- Timeline

Interviews
I1 -Letter dated 21 September 2017 from Duncan Lewis
I2 -Letter dated 22 December 2017 from Duncan Lewis solicitors
I3 -Report by Dr Amlan Basu
I4 -Interview record for DCO Sanders
I5 -Interview record for DCM Loughton
I6 -Interview record for DCM Yates
I7 -Statement by Jon Collier NTRG
I8 -Interview record for DCO Fraser
I9 -Interview record for DCO Francis
I10- Interview record for Nurse Buss
I11 -Interview record for DCM Dix

Name:	Julie Galvin	Name:	Tony Lennon
Grade:	Investigating Officer	Grade:	Sr Investigating Officer
Signed:	**Signature**	Signed:	**Signature**
Date:	22 February 2018	Date	22 February 2018

TIMELINE

The time line sets out the relevant documentary evidence, the Panorama footage and the CCTV and Body Worn Camera footage where it exists in chronological order.

Emergency Travel Document Records

CID records showed that :

9 March 2017 D1527 was detained by the Home Office under immigration powers at HMP Belmarsh.

10 March 2017 a case officer in Op Nexus High Harm was allocated D1527 case and the same day the officer requested an emergency travel document was arranged (ETD).

22 March 2017 at HMP Belmarsh an immigration officer was scheduled to conduct an ETD interview, which was cancelled as D1527 wanted his solicitor present.

5 April 2017 the rescheduled interview was conducted (in Brook House IRC) and an ETD application was made to the Egyptian Embassy.

Annex **A Summary of the Records of D1527 detention at Brook House IRC**

4 April 2017

D1527 was transferred from HMP Belmarsh to Brook House on an open
1 ACCT (ACDT). The Reception Induction Record incorrectly stated D1527
was not on an open ACDT, which would have required a DCM to review the
2 room allocation. However D1527 open ACDT was noted and an IS91 RA
3 was completed and an ACDT review (number 6) was carried out by DCM Lyden and DCM Cook. (The previous case reviews were conducted at HMP Belmarsh). They explained the care plan to him. They recorded that D1527 was happy to be out of prison and he asked to speak to his solicitor and was told he would be given a phone and staff could assist him with the call. He was put in a single room for the first night but was advised he may be asked to share in the future. D1527 was seen by healthcare and an appointment was made for him to see the doctor and RMN. No medication for D1527 was handed over to Brook House staff yet this was not noted as a medical concern on the Reception
1 Induction Document D1527 was placed on B Wing, the induction wing.

5 April 2017

4 ACDT review (number 6) meeting took place at Brook House IRC. D1527 was encouraged to make an appointment for a Rule 35 assessment from the doctor at Brook House IRC. D1527 was due to have an emergency travel document interview that day. D1527 stated he had no thoughts of self-harm

and the observations remained the same, ie one observation every 3 hours and 1 conversation per day was to be maintained.

7 April 2017

5 During ACDT review (number 7) at 16:00 hours D1527 stated that he was not good and that he needed medication for his neck and he had not had his anti-depressant medication '*lately*'. The nurse advised the anti-biotics for his neck would arrive on 8 April 2017 as the doctor had completed the prescription that day, his anti-depressant medication was now in stock and he needed to collect it at lunchtime each day. D1527 stated he was '*sometimes struggling with anxiety attacks'* and he was reminded he had an appointment on 12 April 2017 with RMN. D1527 stated that he had occasional thoughts of self-harm but would approach staff. The next review was for 12 April 2017. The level of care was to remain the same.

8 April 2017

6 The ACDT on-going record showed D1527 was advised he would be moved
7 to A Wing and he had no issues. ACDT review (number 9) was held at 11:25 hours. D1527 refused to attend B Wing office so DCO Attwater went to D1527 D1527 who was playing pool. DCO Attwater commented that D1527 had been laughing with his friends and his demeanour changed when he saw her. D1527 D1527 refused to speak to the officers and the level of observations was reduced as staff had witnessed his general good mood.

8 **00:15 hours** the ongoing record showed D1527 was banging his window with both hands but he stopped when staff intervened. He had a card, (id or business card) in his hand.

00:29 hours the on-going record showed D1527 was sat on his bed quietly.

00:45 hours the on-going record showed D1527 was banging and found at the sink. He said he had a lot going on in his head and he had not had his medication for five days. He said he had hurt himself and he showed DCO Thomas his wrists which were scratched. DCO Thomas called for assistance. The wounds were not bleeding and no treatment was required.

9 **01:55 hours** ACDT review (number 10) was held. D1527 was considered as a raised level of risk. The report stated 'D1527 *was hard to engage with as he showed a very immature attitude; he had made very superficial scratches to his left wrist.*' D1527 stated he would not try to harm himself again and his observations were raised to one an hour.

10 **11:25 hours** DCM Attwater referred in the on-going records to review 8 and that D1527 refused to speak to officers. Review 8 has not been identified.

9 April 2017

11 13:15 hours ACDT review (number 11) ,an emergency welfare case review, was

held '*after an incident in another establishment'*. It was not clear what this referred to. D1527 was playing pool with a group of friends and requested some shoes as he had to borrow them from others. He was not sleeping well but healthcare were present and had no concerns.

12 **14:40 hours** the on-going records said D1527 was calm and asked about his medication and the DCO told him the time, 13:30 hours. D1527 went back to his room.

16:05 hours DCO Lunn recorded in the on-going record that D1527 kicked a chair and threw a chair across the wing and went to his room and slammed the door shut due to being told he had to collect his medication**.**

12 **16:35 hours** DCM Attwater recorded on the on-going record that D1527 *presented at the B wing office with superficial cuts to his left wrist and claims to have made the cut with a razor blade, taken to healthcare for wound to be cleaned and dressed'.* Healthcare confirmed it was a superficial wound which did not require further treatment.

13 **17:00 hours** an emergency case review, ACDT review (number 12), recorded that D1527 cut himself in his room after he did not collect his medication at 13:30 hours. At 16:05 hours D1527 asked for his medication at the wing office. The officer could not get through to healthcare so D1527 threw a chair down the wing in frustration and returned to his room and cut himself with a razor blade. He returned to the wing office to request a plaster and was taken to healthcare. D1527 said he had bad news that the Home Office were putting his travel document together. He was to be observed once an hour. Incident
14 Report BH/252/17 at 16:35 hours recorded the same account. The on-going record recorded that D1527 was spoken to at length about what he had to do regarding his immigration case and what time he had to collect his medication.

15 A Report of Injury to a Detainee was completed and D1527 was seen by Healthcare and had a superficial cut to his left wrist, 4 cm in length. It was cleaned and a dressing applied.

12 19:40 the on-going observation stated D1527 returned with some medication

10 April 2017

16 ACDT review (number 13) at 15:10 hours. D1527 had taken his medication and was in good spirit. He would visit healthcare tomorrow to pursue his Rule 35 claim. His level of care was reduced.

12 April 2017

17 ACDT review (no number) at 16:15 hours. An emergency review took place after he had a RMN appointment with a nurse and said he had nothing to live for and would tie a bed sheet around his neck. D1527 was not engaged with staff and he said he was upset his friends could not arrange to visit him as the appointment line was busy. DCM Cook assisted in facilitating the visit

arrangements which D1527 was happy with. He did not request anything further. The level of observations was increased to one an hour.

18 ACDT review (number 14) took place at 11:15 hours. D1527 was in good spirit and had seen his solicitor and was attending healthcare regularly for his medication and had a Rule 35 appointment later that day and an RMN appointment. The level of observations was reduced.

15 April 2017

19 ACDT review (number 15) D1527 was concerned his medication was not working and DCM Dix advised him if this continued he should see healthcare. D1527 D1527 said he felt frustrated but had no thoughts of self-harm. His observations were reduced.

17 April 2017

20 ACDT review (no number) an emergency case review was held after healthcare raised concerns about D1527 DCM Aldis went to D1527 's room. D1527 D1527 was having problems sleeping and DCM Aldis suggested he saw the doctor. No other issues were raised.

21 **19:25 hours** the on-going record recorded D1527 requested to leave the wing to collect his medication as he forgot and did not take it the previous day.

21:00 hours the on-going record recorded D1527 was agitated as he had not had his medication for three days.

22:11 hours DCM Davis recorded in the on-going record that D1527 was in a low mood, his vital signs were checked and were in normal range, he stated he cannot sleep and self-harmed today. Cuts on his left upper arm were observed and were superficial. The writing was illegible but D1527 was encouraged to see the doctor and attend the RMN and to talk to Sensitive/Irrelevant DCM Davis reported this to the Oscar 1 and 2.

22:20 hours the on-going records state that '*an emergency case review was held*'. No other record of this has been identified.

18 April 2017

22 ACDT review (number 16) was held at 11:30 hours. D1527 did not engage and was reminded of his healthcare appointments. D1527 had not eaten the day before as he had no appetite. The on-going records show two DCMs request the ACDT Care-map is updated, this is not identified. The on-going record showed D1527 refused lunch.

16:42 hours the on-going records showed D1527 requested to come off 'single occupancy' so he could move to C wing and share a room. D1527 refused food in the evening.

19 April 2017

12:40 hours the on going observations record that D1527 refused food at
23 lunch. ACDT review (number 17) noted D1527 refused to engage and was considered a formal food refuser as he had not eaten a centre meal for 48 hours, although he had purchased snacks from the shop. He did not engage with the RNM attempting to make observations. It was reported D1527 only engaged with his case manager DCM Hayley Attwater and so the next review was scheduled with her.

24 **17:50 hours** the on-going record stated D1527 collected his evening meal.

21 April 2017

25 ACDT review (number 18) at 10:00 hours D1527 was in a low mood and stated he was not taking his medication regularly as he forgot. D1527 was happy on C wing with his roommate. He gave no assurance about self-harm. He was unable to see the RMN due to a visit so his RMN appointment was re-arranged for a later time. He remained on hourly observations.

26 **12:58 hours** the on-going record stated D1527 did not have lunch.

16:45 hours the on-going record stated D1527 went to the RMN appointment.

17:09 hours the on-going record stated D1527 did not look well, he looked faint. Officers called Healthcare but D1527 refused to have any observations.

27 **17:20 hours** ACDT review (number 19), an emergency case review was held in D1527 room as he had told the RMN that he would hang himself. When DCM Attwater arrived on C-Wing staff told her they had called healthcare as he appeared unwell when he was locked up for roll count. D1527 was lying on his bunk covering his face and refused to let staff or healthcare examine him as he wanted to be left alone. He had not eaten and remained on hourly observations with mealtime observations.

19:40 hours the on-going record stated D1527 was seen in the queue for the barbers.

20:35 hours the on-going record stated D1527 collected his medication from healthcare.

22 April 2017

28 ACDT review (number 20) at 08:55 hours. D1527 engaged in the meeting. It was recorded that D1527 was seen laughing and joking with detainees around the centre but his demeanour changed with staff. D1527 said he had no thoughts of self-harm and the RMN asked him why he told her differently the day before. He had an appointment with her at 18:30 hours. The care level remained the same. D1527 was recorded on the on-going record as not

having collected lunch, but he was later seen eating in his room with friends. He did not collect his supper.

22:15 hours the on-going record stated D1527 covered the viewing panel with toilet role.

23 April 2017

29 The on-going record stated:

D1527 did not collect lunch or supper from the servery.

20:10 hours D1527 was given paracetemol.

22:00 hours D1527 room mate called staff as D1527 was unwell, he wouldn't come to the door was unresponsive. DCO Jones called healthcare.

22:10 hours D1527 said he was upset as he had a headache and can not sleep.

22:30 hours D1527 repeatedly had been banging his head against the cell door for 5 minutes and would not engage in a conversation.

23:05 hours D1527 was in bed under a blanket and appeared to be sleeping.

24 April 2017

30 **00:00 hours** Incident Report by DCO Jones stated he answered the buzzer to D1527 roommate who asked him to come to their room and then indicated through the hatch that D1527 was cutting his wrists. DCO Jones called for another officer and they entered the room but D1527 would not show the officers his wrists. The two roommates were asked to leave and three further officers attended. They spoke to D1527 who had self harmed and cut his wrists. DCM Aldis persuaded D1527 to move to E Wing. DCM Lydon recorded that a ligature made of bed sheets was found in the room. D1527 was placed in a sterile room on E wing and an appointment was made to see the doctor.

31 Healthcare attended and staff completed a F213 recording D1527 had superficial cuts to his wrists.

32 **00:45 hours.** An emergency ACDT review (number 21) was held after D1527 D1527 roommate called for assistance as D1527 had cut himself. He was found to have a noose around his neck. Healthcare present and advised D1527
33 D1527 had an appointment with the doctor the following day. An Eden Wing Initial Assessment was carried stating the move was for high level observations on
34 ACDT. A Self Harm Incident Investigation was also conducted. No Room Clearance report was identified.

35 **08:15 hours** the on-going record showed D1527 refused to be examined by Healthcare. He refused breakfast and lunch and asked to return to the wing.

36 **15:30 hours** ACDT review (number 22) was chaired by DCM Ring. D1527 was withdrawn and did not make eye contact. He stated he just wanted to return to his old room on C wing. After the review DCM Ring called C Wing to see if he could return but a detainee had already moved in. When he informed D1527 of this, he returned to his room and threw his chair at the door. DCM Ring asked officers to keep an eye on D1527 and a few moments later he was alerted that D1527 had ripped up a sheet and wrapped it around his neck. This was immediately removed by DCM Ring and it was recorded that D1527 did not wish to be seen by healthcare. D1527 was placed on constant supervision. D1527 refused to communicate with staff. The next case review should be with the Duty Director present.

37 The ACDT Caremap showed DCM Ring added actions from his case review as D1527 was not sleeping well and he was to speak to the doctor about his medication. D1527 agreed to go the healthcare tomorrow for a doctor's appointment. It was unclear when this action was completed. A second action was recorded, D1527 needed a battery for his phone and DCM Ring would contact reception for a new one. It was unclear when this was completed.

38 DCM Ring also completed an IS91RA recording D1527 was placed on constant supervision *'after attempting to ligature with his bed-sheets'*. This was sent to DEPMU and has a corresponding entry on CID.

39 An Incident Report (BH295/17) and a Use of Force DCF2 was completed by
40 DCM Ring. These recorded that unplanned force was used and healthcare attended after the incident. It was stated that the events leading up to the incident were that D1527 was *'told his room had been given to another detainee before a room clearance was done'*. DCM Ring was alerted by DCM Browne to an incident and he entered D1527 room and saw D1527 lying on his bed with a sheet wrapped around his neck. DCO Croucher was attempting to remove D1527 hands from the bed sheet. And DCM Browne was securing D1527 legs as D1527 was struggling against them. DCM Ring was about to cut the ligature when D1527 released the ligature and removed it himself.

41 A Self-harm Incident Investigation was completed which stated DCM Ring started to cut off the ligature but D1527 released the hold on the ligature so it was not necessary to remove fully by knife. DCO Gary Croucher and completed
42 DCM Browne both completed an Annex A Use of Force statement corroborating
43 the other reports. Nurse Morley attended and completed a F213 stating D1527
44 D1527 did not wish to be examined. DCM Ring completed a Report of Injury to
45 Detainee

15:40 hours DCO Kelvin Sanders took over constant observations for D1527 D1527 **This featured in on Panorama which showed that DCO Sanders later stated he had banged and held** D1527 **head against a table and pulled his fingers back hard**

46 DCO Sanders on-going records stated:

15:50 hours D1527 *s still laying on his front appears to be crying. Ask him what was wrong-no response.*
15:52 hours D1527 *was banging his head on the base of his bed repeatedly I went in to prevent him doing any further damage.*
16:03 hours D1527 *is trying to drive his index finger either side of his neck with extreme pressure- I have asked him to stop or I will place hands on his hands to pull them away to prevent him injuring himself*
16:16 hours D1527 *keeps banging his head on the base of his bed I am trying to talk him out of it and to sit up and talk to me so I can try to help.*
16:35 hours D1527 *continues to cry with his head on the base of the bed.*
16:47 hours D1527 *has engaged in conversation and is now talking to me, wished to go to* Sensitive/Irrelevant
17:05 hours *Operations manager Caz Dance-Jones has come into* D1527 *room to see what's wrong.*
17:15 hours *DCM Stewart Povey came to speak to* D1527 *as he wishes to return to C wing.*
17:34 hours D1527 *appears to be calm and engaging in more depth conversation.*
1747- 18:30 hours DCO Copping conducted the constant observations during which time D1527 had a shower and played pool with another detainee.
18:30 hours DCO Sanders continued the constant observations and escorted D1527 to Sensitive/Irrelevant
19:00 hours they returned to the wing and D1527 played pool with a detainee.
19:15 hours D1527 asked DCM Povey if he could go to D wing garden, this was agreed by DCO Sanders had to accompany him. DCO Sanders then escorted D1527 to Sensitive/Irrelevant
20:40 hours D1527 has returned to E Wing but refused to move rooms. He watched detainees play pool.
20:45 hours DCO Sanders stopped conducting the constant observation.
21:39 hours D1527 refused medication
21:40 hours D1527 asked if the officer was going to watch him all night and he was pacing around and said he felt he was going to go mad in the room.
21:42 hours D1527 refused to take medication unless he was returned to a normal wing. This was refused.
21:48 hours D1527 walked out of his room and put the tv on and said if the officers cant bring him a tv in his room he will sit on a sofa on the wing. The officers allowed the tv on quietly while they tried to sort out a tv.
22:15 hours the DCM asked D1527 to go to his room and a tv would be found, D1527 replied he wanted the tv first.
22:28 hours D1527 now has a tv and is in room.
22:35 hours D1527 complained the tv wasn't working, the officer fixed it.
22:39 hours D1527 complained the tv was not working. He then covered himself in his blanket.
23:00 hours the officer did not have a good view so entered D1527 room to ensure he was safe and had no marks or ligatures.
23:12 hours strange noises were heard from D1527 it sounded like choking

but he was upset.
23:16 hours D1527 phone rings but he made no attempt to answer it.
23:18 hours the phone rings again. D1527 is making strange crying noises.
23:27 hours D1527 was sick in the toilet.
23:35 hours D1527 is still upset.
23:55 hours D1527 is on the phone.
D1527 continued to have constant observations and had many conversations on the phone during the night.

25 April 2017

33 A review of the Eden Wing Initial Assessment was completed by DCM I MacDonald (untimed) '*It stated "currently in constant supervision after trying to self strangulate yesterday evening. To remain on E wing with no association".*

47 The on-going observations showed D1527 left his room and played snooker with the detainees and watched the tv with a DCO.

48 At **10:45 hours** ACDT review (number 23) was conducted. DCM Steve Loughton, Jo Buss Healthcare and the Duty Director were present. D1527 was assessed as high risk and he stated he had harmed himself as he wanted to return to C Wing and this was the only thing which would stop him self harming and he would not eat. However his room was not available. It recorded that D1527 was not cooperative in the review and '*he made no eye contact throughout and appeared manipulative in his responses. He spoke minimally but seemed to only respond when he wanted something and made threats when he was informed as to the reason why he was on the document and why he was on Eden wing'*. He remained on constant supervision.

49 The constant supervision ongoing events records showed that:

11:20 hours DCO Paschali escorted D1527 to Sensitive/Irrelevant
11:45 hours D1527 returned to E wing.
12:00 hours D1527 refused to return to his room for roll count, recorded by DCO Paschali.
12:00 hours DCO Paschali recorded D1527 was back in room after being aggressive.
13:30 hours D1527 was taken to Sensitive/Irrelevant
14:40 hours D1527 said he was going to the wing courtyard to chat to his friends and if he returned to E wing at that moment he would cut himself.
14:50 hours D1527 was shouting in Arabic to his friends
15:20 hours D1527 refused to leave the courtyard saying he wanted to be taken by force to the wing. He was getting very irate.
16:16 hours D1527 was escorted to healthcare to collect his medical report.
16:28 hours D1527 refused to return to E Wing.
16:30 hours D1527 moved to an interview room.
16:38 hours D1527 refused to return to E wing.
16:39 hours D1527 put an unknown object in his mouth.
16:45 hours D1527 removed the object- a battery.
16:43 hours D1527 refused to walk and said "force is needed"

16:55 hours D1527 returned to E wing without issue.

50 At **17:10 hours** a Care and Separation DCF1 Rule 40, log reference BH/171/17 was completed and D1527 was removed from association. The record showed G4S managers, the Home Office, the IMB, Religious Affairs and
51 Healthcare were advised. An IS91RA Part C was created by officer I Macdonald stating D1527 was placed on Rule 40 '*to maintain good order and discipline in the centre as he was refusing to return to Eden wing under constant supervision*'. This should have been sent to DEPMU but there was no
52 corresponding entry on CID. A Removal from Association Initial Health Assessment was carried out by Nurse Buss who concluded D1527 would not be harmed for a period in Rule 40.

49 The on-going observations showed D1527 had his meal in his room and then lay on his bed. They recorded:

18:52 hours the on-going records showed D1527 asked why DCO Fraser, on constant watch, had not opened his room and DCO Fraser explained it was because of his behaviour he was placed on Rule 40.

19:00 hours CCTV showed DCO Fraser was on constant observations and was sat outside D1527 s room. He was looking through the glass panel to observe D1527 using his hands as if to get a clearer view.

49 **19:01 hours** DCO Fraser records on the on-going record that D1527 kicked and banged the door.

19:06 hours CCTV recorded DCM Loughton entered E Wing. DCM Loughton explained he was Oscar 1, the duty manager and he was reviewing food refusals and wished to review D1527 ACDT and to review the observations. DCO Fraser informed him he could not see D1527 and therefore DCM Loughton said they had to enter the room. He found D1527 around the toilet with a ligature made from a t-shirt around his neck. DCM Loughton cut the ligature off and asked D1527 to sit on the bed. DCM Loughton recalled D1527 was very upset and that he put a battery in his mouth.

This scene was shown on Panorama. DCM Loughton was seen on the programme to cut a ligature off D1527 who was lying in the toilet area of his room. DCM Loughton said '*its all right Ive got it off his head*'. DCM Loughton then told D1527 to sit on the bed and says ' *Come on, on the bed'* D1527 responds ' *I will die here. You force me to go in, I go in. I ask nicely for TV! I ask nicely for everything! you said no! No I ask now, you say no! I come nicely! I will die here today. I will die, I will die now, Later, soon I don't give a damn I will die!".*
DCM Loughton then said '*he's got a battery, give me the battery! don't put it in your mouth!' 'He's got a battery in his mouth"*
'*What we gonna do, just sit here all flippin' night? Take the battery out your mouth".*

50 Control records showed that a call for First Response to attend D1527 s

room was made at 19:11 hours. No further calls for First Response were made that day. CCTV records that other officers attended as first response including healthcare and DCM Ring. DCM Loughton stated that he therefore decided to
51 leave to write up his paperwork. DCM Loughton completed an Incident Report
51 (BH/302/17) and an Annex A Use of Force statement. No Self-harm Incident Investigation Report was identified.

Panorama then showed Nurse Buss (obscured) asked by DCO Tulley outside the room "*Do you know what actually his problem is?*" She responded " *He's an arse basically"*
The footage cut to DCO Paschali, DCO Tulley asked "How old is this guy?" DCO Paschali responded " *he's going on like he's fucking three"*

The footage then shows DCM Ring jumping up and down saying "plug *him in, he'll be a Duracell bunny'* " *If he wants to suck on a battery he can suck on a battery" ," If that's what he wants to use as his dummy, fine I'm happy* with that". DCO Ring says "*Do you want to watch him for a bit Callum?*" DCO Tulley agrees.

The CCTV showed the likely corresponding timeframe.
19:30 hours DCM Ring and DCO Fraser were trying to looking through the window into D1527 's door. Nurse Buss, DCM Yates and DCO Tulley are present.
19:31 hours DCO Tulley leaves the area.
19:31:41 hours DCM Ring opened the door and entered D1527 's room with DCO Fraser. DCM Yates stood in the door and DCO Tulley returned and stood behind DCM Yates. Nurse Buss was outside the room. DCO Yates explained at interview that D1527 had gone to the toilet area of his room and they could not see him so the entered to make sure he was ok.
19:31:53 hours DCO Tulley entered the room.
19:32:08 hours Nurse Buss entered the room.
19:32 hours DCM Yates moved into view at the doorway and then leaves E Wing.
19:33 hours DCM Ring left the room and E Wing.
DCO Tulley was left in the room with DCO Fraser.

Panorama showed what happened next. DCO Tulley said what followed was the most distressing treatment he sees of a detainee undercover at Brook House.

DCO Tulley said "*what are you doing? Stop it! Stop! mate don't do that! don't do that! don't do that! guys please give us a hand. He's trying to strangle himself with his hands. Stop! Get your hands off. Don't do that!"* DCO Tulley commented that *"Yan comes in to help and holds his head to my left'*. DCO Paschali was seen knelt with his legs either side of D1527 D1527 head. At first DCO Paschali's hands were on D1527 's neck and D1527 is moaning.

The footage then cut to show DCO Paschali with his hand in on his knee. *'Relax!'* was said, then D1527 struggled and cried out. DCO Pashcali

put his hands around D1527 's neck. He leant forward and said *"Don't fucking move you fucking piece of shit... I'm going to put you to fucking sleep".* DCO Tulley spoke on the camera and said DCO Paschalli *"pushed his fingers into D1527 's neck and was pushing so, so hard I could hear the detainee trying to gasp for breath".* On camera DCO Paschali had his hands around D1527 's neck and D1527 was making noises if he was struggling to breath.
DCO Tulley said to the camera he thought DCO Paschali was going to kill him. DCO Tulley said *"Yan, Yan Easy"* DCO Francis was heard saying *"are you going to stop being a tool now? Are you going to stop being an idiot? Yes or no?".* DCO Paschali's hands were now at the side of D1527 's neck. DCO Francis said to put D1527 in the recovery position. D1527 D1527 was moaning. DCO Francis then said " *Come on we are getting bored of this now, come on what are you a man or a mouse."* DCO Fraser was seen looking over this manoeuvre. DCO Tulley said *"come out the cell mate"* and the officers left.

CCTV showed the corresponding footage:

19:34 hours DCO Francis, followed by DCO Paschali entered **D1527** 's room. DCO Tulley, Nurse Buss and DCO Francis were already in the room.
19:34:23 hours Nurse Buss moved in the doorway.
19:34:35 hours Nurse Buss left the area.
19:35 hours the door closed.
19:35:02 hours Nurse Buss returned and the door was open
19:35:24 hours Nurse Buss was outside the room arranging medical equipment on the floor. She re-entered the room and then appeared at the door at 19:36
19:36:33 hours DCO Fraser left the room and the area. Nurse Buss entered the room with her back to the officers.
13:37 hours DCO Fraser returned to the room, left, re-entered almost immediately.
19:39 hours Healthcare staff, Bethany Judd, stood alone at a distance outside the room, watching.
19:40 hours Nurse Buss was seen at the door briefly.
19:41 hours Bethany Judd left E Wing.
19:42 hours Nurse Buss left the room, followed by DCO Tulley and DCO Fraser then DCO Francis followed by DCO Paschali.DCO Tulley looked upset and bent over and touched his face and he left .
19:42:49 hours. Nurse Buss re-entered the room and DCO Fraser was outside with DCO Paschali.
19:42:46 hours DCM Dix walked onto E Wing with DCM Yates and they go to **D1527** 's room and stop at the door. DCO Paschali and Nurse Buss talk to DCM Dix. DCO Fraser was not talking.
19:45 hours another manager arrived and DCM Dix entered **D1527** 's room with the other manager and Nurse Buss. DCM Yates, DCO Paschali and DCO Fraser wait outside.
19:46 hours the three left **D1527** 's room. DCO Paschali talked again to DCM Dix at the door.
19:46 hours DCM Dix, DCM Yates, the unknown manager and DCO Paschali left E Wing. Nurse Buss looked as if she wrote her record and she remained with

DCO Fraser at the door of **D1527** 's room looking in.

52 **19:40 hours** the on going records showed an entry at written by Nurse Buss '**D1527** *had a T-shirt around his neck and was angry and upset had a mobile phone battery in his mouth attempted to self strangulate in the toilet . Usual observations only due to demeanour'.*

53 A F213 was completed by healthcare, M Makum, which stated 'detainee had placed a ligature around his neck, removed by staff. *After that he went to toilet and attempted to self strangulate- hands removed from his neck. Slight redness noted on his neck'.*
There were no other documents identified relating to this incident.

54 DCO Fraser resumed his comments on the on-going records:

19:56 hours D1527 was on the floor facing face down.
19:58 hours **D1527** gets off the floor**.**
20:15 hours D1527 is walking around the room looking for something to do.
20:20 hours **D1527** tired to climb the wall.
20:22 hours D1527 got into bed.
DCO Fraser's observations ended at 20:48 hours.
21:00 hours D1527 was allowed to have a shower during roll count
21:20 hours DCO Paschali recorded **D1527** was in his room praying and said sorry.
22:58 hours **D1527** had a pain in his neck and had a red mark and took paracetemol**.**

Panorama showed a later conversation in the staff room Yan said *''Its difficult to explain, Callum had a taste and got a bit upset.''* DCO Tulley said *''I didn't get upset'* and laughed. DCO Paschali then said *''I didn't say you cried, but the likes of us we don't cringe at breaking bones...''*

26 April 2017

10:05 hours **D1527** was removed from Rule 40.

55 **10:40 hours** ACDT review (number 23) was conducted. The review stated '*yesterday* D1527 *attempted to eat a battery from later in the evening he attempted to strangle himself with a t-shirt he was also moved to rule 40 as he had refused to return to Eden wing on a number of occasions. The review of the Rule 40 had concluded he was no longer on Rule 40 so his door could remain open and he could take part in E wing regimes.*' This comment appeared to refer the the incident reported by DCO Loughton only.
D1527 explained that his self harming was due to flashbacks and his medication was not helping. D1527 stated he did not wish to be released from Brook House IRC but wanted to move to the general population and share a room and he stated he would self harm again if this did not happen. He remained high risk on constant observations.

56 The on-going records showed:

19:09 hours D1527 requested a tv in his room and some coffee.
19:29 hours D1527 sat on the sofa in the wing watching tv
19:45 hours D1527 explained to DCO Mawdsley that he has no interest in watching tv in the outside world but its become important to him in Brook House as it acted as a distraction.

27 April 2017

57 **08:09 hours** the on-going record showed D1527 was seen by Healthcare as a food refusal. He said he was drinking, not eating.

58 ACDT review (number 24) recorded D1527 was a lot brighter as a friend was planning a visit and staff would assist in the arrangements. D1527 's phone wasn't working as he had put the battery in his mouth so it was agreed he would be given a replacement today. D1527 wanted to attend Sensitive/Irrelevant and return to the general population. He was advised he can attend Sensitive/Irrelevant and he could return to the general wings if he was not on constant supervision. He was reduced to one observation an hour. A review of the Eden Wing Initial Assessment was completed by DCM N Harris. It stated D1527 was '*no longer on constant supervision, allowed access in centre in afternoon and evening on the understanding that* D1527 *comes back to check in with officers as per ACDT obs.*'

D1527 saw the GP in his room in the morning and the RMN is the evening. He did not eat.

28 April 2017

59 The on-going records showed that DCM Illegible noted the Caremap had not been completed and needed to be addressed at the ACDT review. ACDT case
60 review (number 25) D1527 confirmed his phone was fixed but his friends had not confirmed a visit. D1527 did not engage and his observations remained the same. A review of the Eden Wing Initial Assessment was completed by an unnamed officer stating D1527 can move to another wing and did not need to remain on E Wing.

29 April 2017

61 The on-going record stated D1527 did not have his meals.

3 May 2017

62 ACDT case review (number 27). D1527 was in good spirits and he was sleeping, his medication had been changed and was due to start that night. He was buying food from the shop. Observations were reduced.

4 May 2017

Panorama showed D1527 on netting shouting he did not want t talk to anyone and banging his arms. D1527 says "*Let me go. I'm leaving this*

place. I swear to god I will do it. Leave me alone I say No one talk to me, just leave me alone." **A voice asked *"What are you doing?"* and D1527 responded *"tell him to leave me alone".***
The footage cut to a female voice who said *"He didn't want to do the washing up but he didn't have to go that far, did he?".*
The footage cut to DCO Fraser. DCO Tulley asked him *"What is the best way to deal with someone like that?"* DCO Fraser responded *"Like Yan did"* and he laughed.

63 **16:36 hours** the on-going record stated after a conversation about a plate D1527 D1527 jumped onto the netting and was being encouraged down.

64 Incident Report 325/17 reported that D1527 jumped onto D Wing netting and refused to leave. The Duty Director commented that the matter was brought to a swift conclusion and use of force was used and D1527 was placed on Rule 40 and a full search was authorised.

65 DCM Dix recorded on an Annex A Use of Force that he attended a call for first response and D1527 was on the first floor netting and talking in Arabic but would not interact with staff. Two detainees engaged with him and after 30 minutes D1527 agreed to leave the netting if there were no staff present. DCM Dix agreed and D1527 left the netting and went to the detainees' room. DCM Dix then returned to speak to D1527 who was frustrated by staff. DCM Dix explained they could not leave him alone because of the way he was behaving. D1527 was told he would have to go to CSU on Rule 40 but he refused. D1527 put his hands in his pocket and DCM Dix asked him to remove them, he refused and spontaneous use of force was used. DCM Dix took control of D1527 's right arm, before passing control to DCO Yates. DCM Dix then placed D1527 in handcuffs and he walked to E Wing Room 8 and placed on constant watch. A full search was conducted due to his previous self harm. Nothing was found. DCM Dix noted that D1527 had an issue with DCO Yates so he took over control of D1527 s arm to walk down the stairs.

Body Worn Camera footage was available but it did not capture the entire incident as required by policy. The footage commenced as the officers approached the staircase and D1527 was seen complaining about DCO Yates. DCM Dix then took over the control of D1527 's right arm and they proceed to E Wing without further incident.

66 Use of Force Reports were also completed by DCO Shaukat, DCO Bromley and
67 DCM Yates. DCM Yates stated on his Annex A that he attended D1527 s
68 room with DCM Dix and DCM Dix told D1527 hat he had to move to E Wing while the matter was investigated and D1527 replied *''get your friends to get me I am not going anywhere*''. At this point, he put his right hand in his pocket and DCM Dix asked him what was in his pocket and to remove his hand from his pocket and place them at his side. D1527 replied *''you'll see what's in my pocket"* then he stood up with clenched fists and started shouting. DCM Dix grabbed D1527 's right and DCO Bromley and DCO Shaukat entered the room and restrained D1527 DCM Yates took control of D1527 's right arm. DCM Yates stated DCM Dix placed handcuffs on D1527 and the

officers released the locks on his wrists and held his arm. As they left the room D1527 resistance increased and DCO Shaukat controlled D1527 's head. After leaving the wing D1527 struggled and DCM Yates applied a thumb flextion/lock back onto D1527 D1527 struggled to E Wing. When they reached the top of the stairs it was decided DCM Dix would take over control of D1527 s right arm.

DCO Bromey recorded that at 17:20 hours he was waiting outside a room while DCM Dix spoke to D1527 who was speaking in a loud aggressive tone. At 17:23 hours along with DCO Bromley he entered the room. D1527 had fists closed and tried to reach for his right pocket and swallow his phone which fell. DCO Shaukat took control of D1527 s head. D1527 was compliant once placed in handcuffs and he stood up and was walked to E wing. DCO Bromley's report stated that he controlled D1527 s left arm and his account was consistent with DCO Bromley's.

69 A Report of Injury to detainee and a F213 was completed by K Churcher at 17:45 hours which reported that D1527 had a small scratch to the inside of his left wrist, which was not bleeding.

70 An IS91 RA Part C was completed by DCM Dix. It stated D1527 was relocated to CSU having spent 30 minutes on the netting and coming off (the netting) himself. He spoke to D1527 about the consequences of his behaviour and D1527 's reaction caused concern and due to his history of self-harm he was relocated to Eden wing by force.

71 A DCF1 Rule 40 was completed confirming HO IMB and healthcare were
72 advised and a DCF206 and a Maintenance of Security and Safety Notice was completed. This confirmed D1527 was notificed he was placed in Rule 40 and a healthcare assessment was carried out.

73 **22:15 hours** ACDT case review (number 28) was held. It stated D1527 was relocated to room 8 on E Wing following a use of force and placed on constant observation. D1527 apologised for jumping onto the netting but did not give a reason and said it would not happen again and he understood why force was used and why he was placed on Rule 40. The observations were reduced to hourly.

74 A Room Clearance Certificate was completed which showed D1527 's property was gathered at 20:17 hours and taken to reception.

5 May 2017

75 CID recorded D1527 as a day 6 food refusal.

76 ACDT case review (number 29) He had a RMN appointment today and was feeling well with no thoughts of self-harm. Observations reduced.

10:50 hours D1527 was removed from Rule 40

77 **At 10:35 hours** the Record of actions and Observations recorded that D1527 stated a number of things contributed to him going on the netting.

15:30 hours D1527 was moved to B wing. On arrival at B wing he did not want to share a room but was informed he was no longer on single occupancy.

8 May 2017

75 CID recorded D1527 was no longer refusing food.

78 ACDT case review (number 30) took place in the talking therapy room. D1527 D1527 stated he forgot to go to his RMN appointment on 5 May 2017. D1527 said he was eating and drinking even though he did not collect lunch.

11 May 2017

79 ACDT case review (number 31) took place. D1527 was engaged and got on well with his room mate. He said he forgot the times of his RMN appointment and to collect his medication and that his medication was not working but the appointments with the nurse were not useful. Advice was officered to discuss his issues with the RMN. D1527 went back on the food refusal list, he said he had no appetite but ate food from the shop.

12 May 2017

75 CID recorded D1527 as a Day 2 food refusal.

14 May 2017

80 ACDT case review (number 32) took place in the activities office. D1527 was engaged. It recorded that D1527 was sleeping well, but he wanted to increase the dose of his medication so this is presumed to be a mistake. D1527 D1527 had no appetite but bought food at the shop when he wanted.

16 May 2017

75 CID recorded D1527 as a Day 7 food refusal

17 May 2017

81 ACDT case review (number 33). D1527 was engaged. He bought food from the shop and the cultural kitchen. He stated he was not protesting against the Home Office, he did not like Brook House IRC food. He refused to be weighed and it was commented that he always refused. D1527 remained on an ACDT due to his food refusal.

18 May 2017

75 CID recorded D1527 as a Day 9 food refusal

20 May 2017

75 CID recorded D1527 as a Day 10 food refusal

21 May 2017

75 CID recorded D1527 as a Day 11 food refusal.

82 ACDT case review (number 34) took place. D1527 was not sleeping which made him tired in the day and he wanted to sit in his room. He was not eating as he did not like the food.

22 May 2017

83 An emergency ACDT case review (number 35) took place. D1527 was emotional and aggressive and did not want to talk to any officers, just his friends. Home Office staff contacted the DCO to advise D1527 had some bad news and was in a rage. (No details were provided and there was no corresponding entry on CID). D1527 observations were increased.

23 May 2017

CID recorded D1527 as a food refusal

ACDT case review (number 36) recorded that D1527 did not want to engage with staff or Healthcare staff during his appointments. He was not eating.

24 May 2017

CID recorded D1527 as a Day 14 food refusal, he had not eaten Brook House IRC meals since 9 May 2017)

25 May 2017

CID recorded D1527 as a Day 15 food refusal

ACDT case review (number 37) was attempted but D1527 told the officers to get out of his room and he did not wish to speak to them. He had just been given paracetemol for a pain in his leg.

27 May 2017

ACDT case review (no number) recorded that D1527 requested to come off an ACDT some time ago but he had not been eating consecutive meals. He had since eaten two consecutive meals and had no thoughts of self-harm and so D1527 D1527's ACDT was closed. An IS91RA Part C was issued by DCM Dix.

28 May 2017
CID recorded D1527 as no longer on food refusal

5 June 2017

An ACDT Post Closure Review took place. D1527 was not causing any concern and had no thoughts of self-harm and was sharing a room with someone he got on well with.

15 June 2017

D1527 was granted temporary admission and left Brook House IRC.