D1527 Response to Rule 9 Questions

The table below provides answers to the Rule 9 questions asked by the inquiry by relying on D1527 instructions, documents disclosed to D1527 and the Callum Tulley body work video footage. It is intended to complement the witness statement produced by MA for the inquiry.

No.	Question	Answer
1.	Please provide your full name and any other names by which you are known	D1527 (anonymised- full name is known to Inquiry)
2.	Please provide your nationality and any religious beliefs that you may hold.	Egyptian. DPA
3.	Please provide the dates that you were detained at Brook House, when you were released and why	D1527 was detained under immigration powers on 9 March 2017 at HMP Belmarsh. He was transferred to Brook House IRC in the evening of 4 April 2017. D1527 solicitors wrote repeated letters to the Home Office giving them every opportunity to understand why he should not be in detention. They repeatedly drew the attention of the Home Office to its duties under rule 35 and the Adults at Risk Policy, provided two different independent reports on his suicidality and psychiatric condition; and repeatedly sought to secure his release. In the end he issued urgent judicial review proceedings on 7 June 2017 seeking an interim order for his release from detention. He raised grounds of his severe mental illness and acute suicidality and the absence of a realistic prospect of removal within a reasonable period

		of time. The Home Office contested this application and at an interim relief hearing on 13 June 2017, Cranston J directed D1527 be released. He was released and left Brook House on 15 June 2017. A fuller account of pre-action correspondence and evidence in connection with the hearing is set out in D1527's witness statement The basis of the High Court claim is explained at paragraphs 104-117 of the witness statement.
4.	Please set out which wings were you accommodated and the dates.	From documentation we have been able to work out the following: 4 April 2017 – arrives at Brook House, placed in B-wing room 116 (HOM003036_0029) Appears to still be in B-wing as late as 19 April 2017 despite it being an induction wing (HOM003036_0040) 20 or 21 April 2017 – move to C-wing, room C/005 (HOM003036_0042) 24 April 2017 – moved to E-wing shortly after 00:00 after self-harming in his C-wing room 25 April 2017 – 17:10 – placed on Rule 40 in E-wing 26 April 2017 – 10:05 – taken off Rule 40 but remaining E-wing 28-30 April 2017 – at some point on these dates moved to D-wing – room 1 (HOM003036_022)

		4 May 2017 – taken by force to E-wing on Rule 40 5 May 2017 – removed of Rule 40 at 10:50. Moved to B-wing at 15:30 but said to complain about prospect of sharing a room. 5-9 May 2017 – at some point during these dates moved to C-wing room 208 (HOM003032) 27 May 2017 – records still in C-wing room 208. Understand he may have stayed in that room until his release on 15 June 2017
5.	When you arrived at Brook House were you provided with an "induction"? If so, pleasesummarise what this involved, for example a. How soon was it after arrival; b. Whether it involved, for example, an interview, tour of a building, or a visit by healthcare professional or anyone else; c. Whether it was during daytime or night-time; d. Whether you had access to an interpreter if needed/requested; e. How long the process took; f. Whether you were given any written materials;	Please see D1527 witness statement at paragraphs 19-24

	g. Whether you were able to and did follow up any aspect of the induction if youwanted to; h. Whether you were informed of your rights as a detainee (and if so, what you weretold); i. Whether you were accommodated in an "induction wing" for the first night ornights of your stay; j. How satisfied you were with the induction process; k. Whether you met any detainee welfare officers.	
6.	Please refer to documents CJS006036, CJS006037 (induction records): which record that you did not have an induction tour on 4 April but that you did have a tour on 5 April. a. Did a tour or tours take place? b. Did they cover all areas of tour shown on the list? c. Did they cover an induction talk at the same time? d. Did they cover all aspects of the induction talk shown on list?	Please see D1527 witness statement at 19-24

7.	Please refer to documents CJS006036, CJS006037 (induction records): which record, in respect of specific needs or issues raised during reception procedure by Reception Officer, "no" to thoughts of suicide/self-harm, no ACDT, no immediate/urgent needs. l. do you recall being assessed? m. do you recall answering "no" to these issues?	Please refer to D1527 witness statement at paragraphs 19-24. As confirmed by his medical records at 19:26 on 4 April 2017, D1527 was on an open ACDT when he arrived at Brook House for suicidal threats whilst at HMP Belmarsh with three observations per hours. The officer completing the induction record should have known and had this information to hand and D1527's self-harm/suicide risk accordingly flagged immediately upon induction. This is a concerning oversight. There are concerns about the extent to which proper information was taken from D1527 with regards to this induction process and how he was ultimately treated and managed within detention. D1527 is recorded as being able to read and write in English. However he cannot do so (neither can he read or write in Arabic). The fact he is unable to read or write is recorded in his IRC medical records. It is unclear if there was an interpreter present for this induction.
8.	At this point did you see any healthcare professional?	The IRC medical records confirm he was seen by Staff Nurse Lyn O'Doherty on 4 April 2017. An entry at 19:26 confirms this. It is unclear if this is the time he was seen or the time the entry was recorded into his IRC medical records.
9.	Did you know whether the healthcare professional had your previous medical notes?	This is unknown to the client and unclear from the IRC medical records. His solicitors were faxed a copy of the medical records on 26 April 2017 and these did contain entries from HMP Highdown and HMP Belmarsh but we cannot confirm if they were sent to Brook

		House on D1527 arrival. The relevant parts were referred to by us in correspondence and in the Dr Thomas Report subsequently.
10.	Did you feel able to and did you raise any concerns about your health at this stage? How were your concerns dealt with?	D1527 was never offered an interpreter (WS para 21). When he did report matters to Healthcare they would say he was just playing (WS para 40). The initial healthcare screening on 4 April 2017 confirms MA's reluctance to say much about his health upon arrival which is entirely understandable given his vulnerabilities and trauma – e.g. "appears quiet compliant but would not elaborate… appears quiet – reluctant to talk much". It was not until 11 April 2017 that D1527 felt able to approach healthcare to seek a Rule 35 report. Even then, that request was prompted following a visit by our firm to Brook House on the morning of 11 April 2017 where our caseworker, Alex Schymyck, advised D1527 that he should request a Rule 35 assessment given he had disclosed an account which confirmed he was a victim of torture. Prior to this, our client's concerns regarding his health were being raised directly with the Home Office by our firm. We wrote to DEPMU and Home Office official Amanda Radcliffe on 31 March 2017 seeking a transfer out of Belmarsh, noting that he would meet all elements of a Rule 35 (1, 2 and 3) if he was in an IRC and entitled to access the Rule 35 process. We wrote to Shane Byrne, his Home Office caseworker in the Operation Nexus team on 5 April 2017 again seeking a Rule 35 assessment to be completed upon his arrival at Brook House. Shane Byrne responded on behalf of the Home Office on 6 April 2017 stating that the "onus was upon your client to raise any concerns he has about his continued detention to staff at the removal centre. Once these concerns have been raised and

		documented, then the Home Office will consider". A written request for temporary admission was then sent on 6 April 2017 enclosing a letter from Tiago Brando, his community psychotherapist who expressed serious concerns about his well-being in immigration detention. We also set out concerns about the Home Office's response of placing the burden on D1527 to raise concerns about his own vulnerability and ill-health despite being advised by our firm (with professional medical evidence) that he engaged the Adults at Risk policy, was a victim of torture, seriously mentally unwell and a suicide risk. (HOM0000101/ HOM000345))
11.	If any medication had been prescribed for you prior to your arrival at Brook House, was this continued? a) Please consider document SXP000145 which is a witness statement given to thepolice, in which you said that when you first arrived at Brook House you were prescribed Sensitive/Irrelevant (a depression medication), yet it took over a week before being told it was available (p.1). Please also consider document CJS001146 which on 8 April 2017 comments that you had not taken medication in 5 days. b) Are these accounts accurate? c) Please set out any to any other medication issues you had on arrival.	D1527 account is consistent with the IRC healthcare records. He was not issued with his Sensitive/Irrelevant until 8 April 2021- see medication section. An entry dated 4 April 2017 at 20:13 by Nurse Lyn O'Doherty confirms 'no medication handed over on admission'. An entry by Dr Chaudhary at 15:20 on 5 April 2017 confirms that Sensitive/Irrelevant will be issued but not until 8 April 2017 ("Future dated medication 08 Apr 2017"). An entry at 16:48 on 7 April 2017 confirms was "not happy that he has had to wait a couple of days for his medication to arrive".

12.	Please consider documents CJS006036,CJS006037 (induction records), which state in respect of the first 24 hour interview, that when asked if you have ever suffered with depression, "no" is circled a) Do you recall answering this question? If so, did you answer yes or no? b) If you said no - why? Were you taking medication for depression?	As set out at question 7, the induction process was flawed. He was not given an interpreter and the officer was unaware he entered on an open ACDT. An immediate consideration of the IRC healthcare records would have revealed D1527 had depression and was being prescribed medication for it at HMP Belmarsh. He made a number of requests for his medication over the following days. He does not recall being asked these questions: see WS paras 19-24. It is evident that even if a screening process was in fact conducted (contrary to D1527's recollection), it was not conducted competently, in particular because it did not involve consideration of medical records, offering an interpreter, or eliciting the fact that he had depression, a fact which he repeatedly expressed over the next few days in seeking his medication.
13.	Please consider documents CJS006036, CJS006037, which are induction records. There is a reference to Information and House Rules for Residents Booklet and basic information issued in a Suitable language, in respect of which "no" is encircled, and you have signed it. a. Do you recall receiving such a booklet? b. Do you recall signing this document?	The induction record suggests D1527 was not given a booklet in a "suitable language" (we assume this means a language he can understand). D1527 cannot read or write in English or Arabic, this was not confirmed in the induction. No contingency process for those who cannot read or write to be given sufficient information about what the booklets contained was deployed. D1527 does not recall receiving the booklet and does not know whether the signature is his because it is redacted (WS para 19)
14.	Were you accommodated in Eden Wing at any point during your stay at Brook House? If so,for how long and between which dates?	Yes. G4S should have a record of all dates in which D1527 was held on each wing but we understand at least on the following dates/times:

	a. Please consider document HOM000517 which suggests that you agreed to go after cutting your wrists. b. Please consider documents HOM032222, HOM032223 which suggest that you were taken there because officers were concerned you had something to hurt yourself or others with after coming off of netting.	24 April 2017 – moved to E-wing shortly after 00:00 after self-harming in his C-wing room 25 April 2017 – 17:10 – placed on Rule 40 in E-wing 26 April 2017 – 10:05 – taken off Rule 40 but remaining E-wing 28-30 April 2017 – at some point on these dates moved to D-wing – room 1 (HOM003036_022) 4 May 2017 – taken by force to E-wing on Rule 40 5 May 2017 – removed of Rule 40 at 10:50. Moved to B-wing at 15:30. As to his evidence of E-Wing, see WS paras 29, 45-47; 61-62; 68; 78-9 and 89-101
15.	Do you know why you were accommodated in Eden Wing? a) Please note SXP000149 which states that at least on 25.04.2017 you were on Ewing.	D1527 was relocated to E-wing in the early hours of 24 April 2017 on the basis of his self-harm and a ligature being found in his room. We would assume G4S took the decision to move to E-wing where they believe detainees' self-harm risk can be better monitored and observed. However the actions taken over 24 and 25 April 2017 show that detention officers had little regard to D1527 risk of self-harm and suicide where he experienced multiple assaults by officers and was placed on Rule 40 (the latter with no regard to the effects on his self-harm/suicidality by removing him from association). D1527 was relocated again to E-wing on 4 May 2017 after a decision was taken to use force to relocate him there from D-wing under Rule 40 and to

		keep him under constant observations. We set out further below why the use of force, Rule 40 and decision to move to E-wing were all unlawful and without justification. As to his evidence of E-Wing, see WS paras 29, 45-47; 61-62; 68; 78-9 and 89-101
16.	Did you agree that it was correct for you to be placed in Eden Wing? If not, why not?	D1527 has set out in his witness statement at paragraphs paras 29, 45-47; 61-62; 68; 78-9 and 89-101why the decisions to place him on E-wing had a detrimental impact on his mental health, and his self-harm/suicide risk. We address at our responses to questions 39-48 below why it was unjustified and unlawful to place him on E-wing during these periods.
17.	Did you share a room? If so, with how many people, with whom and for how long? In terms of their immigration status, do you know if they were challenging their asylum decision, deportation order (ex-foreign national prisoner; i.e. had served a prison sentence in the UK) or other type of immigration decision? What was your experience like sharing a room with this person?	We understand that D1527 did not share a room whilst on E-wing
18.	At any point, was there a third bed in the room?	There are no three-men rooms in E-wing

19.	Was the toilet fully or partially separated from the rest of the room?	
20.	Describe the regime on E wing. In particular: a. How many hours were you locked in your room per day and when? b. What access did you have to activities (e.g. education, training, workshops, exercise etc)? c. Did you have adequate access to healthcare? i. Please consider CPS000011. At page 21 it is recorded that you told Dr Basu that the mental health nurse "did nothing". Is this correct? If so, can you explain what you believe should have been done but was not done? d. Did you have access to translation services? e. Did you have access to phone calls/visits/letters? If so, what was the frequency of this contact and for how long were the phone calls and visits?	Please see D1527 witness statement at WS paras 29, 45-47; 61-62; 68; 78-9 and 89-101
21.	21. How would you describe your experience on Eden Wing compared to that of the other wings that you were accommodated in?	Please see D1527 witness statement at WS paras 29, 45-47; 61-62; 68; 78-9 and 89-101

	a. Please consider document HOM000195, a witness statement you previously provided, in which you state that E-wing was more frightening than being on main wing. Is this correct? If so, in what way was it more frightening?	
Care and Separation Unit		
22.	Were you accommodated in the Care and Separation Unit (CSU) at any point during yourdetention at Brook House? If so, for how long and between which dates? a. Please consider CJS001073 which states that on 24 April 2017 you were placedonto constant supervision. b. Please consider HOM000388 which states that on 25 April 2017 you were placedonto Rule 40. c. Please consider HOM000319 which records that on 4 May 2017, force was used to relocate you to CSU on Rule 40.	Our understanding, and as appears to be confirmed by HOM003036, is that all instances of D1527 being placed under Rule 40 was whilst on E-wing. He was not separately transferred to CSU. His constant supervision took place on E-wing. D1527 Rule 40 took place in his room at E-wing. He was placed on to Rule 40 at 17:10 on 25 April 2017 (HOM000769). The events in which he was strangled by DCO Paschali took place that evening in his room in E-wing as confirmed by the extensive footage of this incident. The decision to place D1527 on Rule 40 and the fact he remained on E-wing is recorded extensively in the PSU investigation of his report – see DJS001107_0052-0056. Although it appears that a decision was taken to take D1527 to CSU on 4 May 2017, it appears that he was in fact taken to E-wing room 008. This is confirmed by the use of force reports – see DCM Dix at CJS005530_0008 and DCO Shaukat at CJS005530_0011 – plus his ACDT review from that day (HOM003036_0020).

23.	Do you know why you were accommodated in the CSU?	n/a
24.	Did you agree that it was correct for you to be placed in CSU? If not, why not?	Understanding that this question is about whether it was correct for D1527 to be placed on Rule 40 when he was, please see fuller responses at questions 39-48.
25.	Did you share a room? If so, with how many people, with whom and for how long	There are no shared rooms in the CSU
26.	Was the toilet fully or partially separated from the rest of the room?	n/a
27.	Describe the regime on the Care and Separation Unit. In particular: a. How many hours were you locked in your room per day and when? b. What access did you have to activities (e.g. education, training, workshops, exercise etc.)? c. Did you have adequate access to healthcare? d. Did you have access to translation services?	n/a

	e. Did you have access to phone calls/visits/letters? If so, what was the frequency of this contact and for how long were the phone calls and visits?	
28.	How would you describe your experience on CSU compared to that of the other wings thatyou were accommodated in?	n/a but please see D1527 witness statement at paragraphs 123-127 about his experiences of being under Rule 40
29.	Were you able to challenge your detention at the CSU? If so, did you and how?	D1527 was unable to challenge his Rule 40 decisions. Rule 40(6) requires a detainee to be given written reasons for the decision to remove from association. The time in which this given to a detainee and confirmation it was handed over should be recorded in the written observations. Neither the written observations for the 25 April 2017 (see HOM000769_10) nor 4 May 2017 (see HOM000251_11) decisions confirm that D1527 was provided with written reasons. Concerned about the 25 April 2017 decision to segregate, Duncan Lewis wrote to Shane Byrne at the Home Office on 26 April 2017 having been informed by D1527 of his segregation the day before. Our letter reminded the Home Office of Rule 40(6) and asked that they were immediately sent to us. We chased this the following day on 27 April 2017. These letters can be found at HOM000241. The Home Office did not respond to us until 3 May 2017 stating: "We can confirm we are in receipt of your correspondence dated 26 April 2017 and 27 April 2017. We are taking your enquiries forward and will issue a response to them once we are in receipt of all relevant information." This response suggests that even by 3 May 2017, D1527 Home Office caseworker did not have access to the Rule 40 decision despite the Home Office being required to be notified – either that or

		Mr Byrne chose not to disclose the Rule 40 decision as soon as reasonably possible. In respect of the 4 May 2017 Rule 40 decision, we understand that it may not have been until 5 May 2017 that D1527 received a copy of his decision. This was faxed to us from Brook House at 8:13pm on 5 May 2017.
Access to legal advice		
30.	Did you have access to legal advice and/or representation, if required?	Duncan Lewis were instructed throughout having first visited D1527 at HMP Belmarsh on 23 March 2017.
31.	You instructed Duncan Lewis solicitors before you moved to Brook House - were you able to contact them when you needed to and were they able to contact you when they needed to? How did you and/or they do so?	See D1527 witness statement at paragraph 129 where he discusses the difficulties in being able to contact our firm when on Rule 40. It is notable that he was put under rule 40 restrictions without access to legal recourse immediately after the assaults by staff and the attempted cover up of the incidents. It is notable also that although D1527 was legally represented, the assaults would not have come to light but for the Panorama filming.
32.	Did you have any role in the casework/detention reviews conducted by the Home Office?	There is no process in which detainees, D1527 are involved in the detention review process. They are entirely left out of this process. See WS para 15. Upon D1527 being detained, his solicitors requested that a rule 35 examination was undertaken and a report produced in order that the Secretary of State could feed into his detention review a proper

		understanding of D1527 vulnerability. That is the purpose of the rule 34 review within 24 hours and should in any event have been automatic. When that did not happen, D1527 solicitors made repeated representations requesting that the evidence of D1527 psychological vulnerability and mental illness in the report of his psychotherapist Tiago Brandao should be considered by the Home Office. The Detention Review and Monthly Progress Reports show that neither was a proper examination by a GP undertaken at the detention centre, nor did the Secretary of State see any flaw in their not being such evidence when he authorised detention. Nor did the Secretary of State in fact take into account the medical report which the solicitors had provided. This is a well-established flaw in the process that has persisted throughout the operation of the detention system since its inception. The Home Office failure to properly integrate rules 33-35 of the Detention Centre Rules has been established repeatedly in litigation since 2006. D1527 case is another instance of that failure. What was legally required was that a competent medical examination was undertaken by a general practitioner within 24 hours. That should have involved consideration of medical records and a report being sent to the Secretary of State. The Secretary of State was legally required to take that information into account as well as the Tiago Brandao report when initially reviewing detention. Applying her policy and any rational approach, D1527 should not have been detained. D1527 legal representatives continued to stress the importance of considering D1527 vulnerability after the initial detention decision. As a result of this pressure a rule 35 examination was undertaken over 12-13 April and considered by the Secretary of State on 18 April. It is

		notable that the examination and report focused on whether D1527 had been tortured rather than on his suicidality, and similarly the Secretary of State's decision focused exclusively on an issue as to whether what Dr Oozerally described as his "credible" account of torture met the definition of torture. It can be seen that that misses the point of the policy of not detaining torture victims which is a concern as to their vulnerability. Thus, although D1527 had through his representatives by this point submitted an expert report and procured a rule 35 examination, there was still no proper consideration given in reviewing detention to whether he should not be detained given his mental illness and psychological vulnerability. See WS at paras 35-39. The document trail confirms that nor did the Secretary of State take account in reviewing detention of the very detailed and alarming report of Dr. Thomas. Indeed, the Home Office resisted the release of the Claimant by the High Court when D1527 sought release on 13 June 2017 on the basis that it wanted to detain him for a further week in order that it could, at that point (ten weeks after detaining him) conduct its own medical examination. See WS – 104- 118. By 13 June, the Home Office had had Dr Thomas' report for two weeks (since 31 May 2017) and a detention review had fallen due and was completed on 13 June 2017 (the day he was ordered to be released), yet even within its regular programme of review the Home Office was unable to accommodate considering the evidence of his mental illness and was asking for *more* time to detain him in order to decide whether to detain him. That was completely inconsistent with the presumption against detention that requires that detention can be maintained where

		justified. The Home Office was acting the other way round: presume that D1527 is detained (even when conducting a review of detention on 13 June until it has got round to reading the evidence that shows he should not be detained. It should be noted that the obligation to review is not limited to the monthly reviews required by rule 9 of the Detention Centre Rules 2001: it is triggered by any significant material that requires detention to be reviewed. The generally unmanageable mental illness; the multiple suicide attempts, the fact that a life directive were being considered; the food refusal; the medical evidence were all occasions that were drawn to the attention of the Secretary of State by D1527 through his representatives and all or any should have triggered active reconsideration of the appropriateness of detention. Had the assaults by staff also been known, that would also have been a trigger for considering the appropriateness of detention.
33.	Were you sent them periodically? If so, how often were you sent them?	Detainees are not sent copies of detention reviews. They are provided summaries of the decisions in the way of 'Monthly Progress Reviews'. From our experience they lack sufficient information/detail about why individuals are being detained and our often inaccurate or misleading. To our knowledge, we are aware of monthly progress reports being issued on 6 April 2017, 16 May 2017 and 13 June 2017 and the principle is that these are the published reasons in compliance with rule 9 of the DCR 2001 that follow the detention review . An example of inaccurate and misleading information can be seen on the 16 May 2017 monthly progress report (HOM000407) where the Home Office claim his ETD application is taking longer than they

		would like "because you have refused to give details of your true identity", however the underlying detention review (HOM005757) does not set out any concerns that the Home Office believe him to be dishonest about his identity. As set out above, the monthly progress reports, like the detention reviews, take no proper account of D1527 vulnerability, mental illness and suicidality.
34.	Did you have access to legal advice and/or representation in order to challenge your detention? Did you need legal advice? Were there any delays in accessing legal advice clinics?	Duncan Lewis challenged D1527 detention under immigration powers, as well as the failure to comply with rules 34, 35 (medical examination) and 40(6) (reasons for isolation) of the detention centre rules repeatedly in correspondence from the very day D1527 was detained (see WS para 11 (4th April); para 12 (5th April), para 37 (13 April), paras 62-5 (26-27 April), para 83 (31 May)). It is clear that no adequate heed was paid by the Secretary of State to any of this. A pre-action letter was sent on 31 May enclosing the Dr. Thomas report (see WS para 83). That letter and report still did not elicit a proper reconsideration of detention and then a claim for judicial review had to be issued accompanied by an urgent interim relief application on 7 June 2017 (DL0000119). The grounds for judicial review can be found at DL00001119_0065. Although the Home Office still did not properly understand or consider the seriousness of the situation, it is clear that the High Court did. Lavender J directed an oral in-person hearing to be heard on an extremely expedited basis on 13 June. Although the application for release was strongly resisted by the Home Office the case went to an interim relief hearing on 13 June 2017 where Cranston J directed D1527 release from immigration

		detention (DL00001119_123) following submissions made as to his suicidality and psychological state rendering his detention unlawful. D1527 was released as a result on 15 June 2017. See paragraphs 103-117
Mistreatment		
35.	Whilst you were detained at Brook House were you a victim of or did you witness any mistreatment or abuse from Brook House staff? If so, please describe for each incident (as far as possible): a. Date; b. Place; c. Name/description/role of staff involved; d. If verbal abuse, what was said? e. If physical abuse: i. what did the staff member do? ii. Did you sustain any injuries, and if so, what was the extent of those injuries? iii. Did you seek and/or were you given medical treatment?	Please see D1527 witness statement at paragraphs 31-31; 47-60; 68-80; and specific responses to questions 39-48 below 00:00 on 24 April 2017 in C/005. D2490 raised the alarm as D1527 had self-harmed. DCO Nick Jones was the first member of staff to arrive, followed by DCO Dave Waldock. Andy Lydon (Oscar 1) and Dave Aldis (Oscar 2) then arrived. D1527 was not willing to go to E-wing. He was forcibly transferred by the four officers. D1527 described the incident in his witness statement: "*On one occasion, a guy who I was sharing a room with called for the staff because I was self-harming, and the staff said I had to go to E-wing. I refused to go; I did not want to be on E-wing. I was sharing a room with two other people at this time, and they said that if I didn't leave they would kick the other two people out of the room and I would have to stay in this room on my own on constant watch. After they took the other two detainees out of the room, they tried to get me to leave the room by force. They grabbed my hands, my clothes, and tried to rip the bedding and mattress from underneath me so that I would fall out*

	f. Did anyone (staff or detainee) witness the incident? If so, who? How, if at all, did they respond? g. Did you make a complaint? If so, to whom? How was it resolved?	*of bed and they could carry me to E-wing. After they said they would force the other two to leave I agreed to come with them to E-wing. This was very embarrassing and humiliating for this to happen in front of others.*" (extract from HOM032221) The use of force against D1527 was not recorded in any documents.
36.	Please provide the same information in relation to any mistreatment or abuse from other detainees.	n/a
37.	More generally, did you on any occasion feel bullied, threatened, intimidated, victimised, treated without respect or unsafe because of a member of staff or other detainees? If so, please explain why.	Please see our client's witness statement particularly at paragraphs 31-31; 47-60; 68-80
38.	Were you or any other detainee that you witnessed, treated badly because of your ethnicity,nationality, religion or sexual orientation? n. If so, please explain how and when. i. Please consider document HOM000196,	As to racism/religious discrimination: Please see our client's witness statement at paragraphs 54-5and Dr Thomas' report at para 159 (quoted at WS para 85.) and para 33 of his witness statement of 19 January 2018 quoted at WS para 49.

	pg 94, in which you state that you *'asked Yan if I could go to the* Sensitive/Irrelevant *and he said "I'm not going to take youto the fucking* Sensitive/Irrelevant - when did this happen? ii. Please consider document HOM003004. When on E-wing on 24-25 April, were you able to go to the Sensitive/Irrelevant o. Did you make any complaints and if so, how were they dealt with? p. Were there any changes to this treatment over the time you were at Brook House? q. Did your treatment depend on the wing you were on or which DCOs were on theshift, or any other factor?	As to abuse on grounds of Sensitive/Irrelevant see WS paragraph 87 and paragraph 159 of Dr Thomas' report quoted at WS 85. As to the failure to take account of issues related to Sensitive/Irrelevant Sensitive/Irrelevant see the Dr Thomas Report. This formed part of D1527 complaints to the PSU – see the specific responses regarding the PSU investigation at question 112
Use of Force		
Specific 24 April 2017 - recorded UoF incident		

39.	Please consider document CJS005538, which is a "Use of Force" form written by several officers about an incident on this date recorded at 15:20 hours. You may also wish to consider CJS000899 and SXP000145, which are witness statements produced by you and Callum Tulley which comment on the incident on 24 April 2017. Is the officer's account set out in the form accurate? If not, please give your account in detail.	D1527 finds it difficult to distinguish specific incidents of use of force, but has set out his recollection to the best of his ability at WS paras 47-49- Callum Tulley was not present at this incident and did not produce a witness statement address it. CJS000899 is a handover log which refers to force being used against D1527 on 24 April 2017 and 25 April 2017 on pages 6 and 7.
40.	Please consider document HOM000784. At pg 2, Nathan Ring says that you removed a bedsheet from your own neck and at pg 3 Gary Croucher says that he unwound the ligature andremoved it. Please comment on your recollection of these matters. r. Were de-escalation tactics used (other techniques before force was used against you; i.e. verbal reasoning)? s. Were you asked to fill out a form where you could give your account of whathappened (called a "de-brief" form)? t. Was the use of force reasonable in your view? If not, why not? u. Is it correct that you refused to see Healthcare after the incident? If so, why didn't you want to see	The officers were not wearing or did not activate body worn video cameras and there is no secret video footage from Callum Tulley because he was not present. D1527 cannot remember this incident because it was one of a number of occasions on which he attempted to harm himself or commit suicide and officers used force against him and he cannot distinguish between the incidents in his mind. He has given his recollections of the use of force in his Witness Statement. There is no record of de-escalation tactics being used and it would not have been appropriate in the circumstances. There is no record of D1527 being provided with a de-brief form. Melissa Morley from Healthcare did attend and document HOM000784 records D1527 stating that he wanted to be left alone and specifically that he did not want anyone to touch him. It is difficult for D1527 to comment on the accuracy of the records made by the officers involved or the reasonableness of the force used. D1527

	Healthcare? v. Do you agree that the reason given for using force was correct; preventing self-harm? w. Did you sustain any injuries? x. Did any other detainee witness this incident? If so, who? y. CJS000611 records that you wanted to return to normal association - why? z. Please set out your account of your time in constant supervision following thisevent.	has concerns that an unreasonable force was used, because Nathan Ring used unreasonable force against D1527 on other occasions and made derogatory remarks about him (see answers to Questions 44, 46, 92 and 120).
41.	In your witness statement to police dated 11 December 2017 (SXP000145) you say that a few days after 21 April, when you had seen a mental health doctor, you were "dragged" to E-wing and staff (4 people) "*used a lot of force*", pushed you against the wall; were abusive andswore at you. You were placed on E-wing and attempted suicide that day 10 times becauseyou were "*very, very low*" and "*angry*". a. Is this the same incident as the above? Please give more detail if possible.	This cannot be the same incident as D1527 was moved to E-wing in the early hours of 24 April 2017 and woke up there. The above incident occurred at 15.20 in the afternoon on 24 April 2017.

42.	Please consider and comment on CJS001030 pg 9; HOM000517 pgs 1-2 and 4-7; CJS001035 pgs 2-3; SXP000155 pg 1; and HOM003004 pg 2 in relation to your move to E-wing on this date, if not covered above	HOM000517 – DCO Nick Jones says D1527 refused to engage but Lydon and Aldis managed to get him to engage through talking. None of documents record how D1527 went from lying face down refusing to cooperate to voluntarily walking to E-wing
43.	Please consider document SXP000120 (Callum Tulley's statement to the police), in which he describes that on 04 May 2017 and on 08 May 2017 he heard DCO Kalvin Sanders braggingabout slamming your head on a desk and bending your fingers back, SXP000057 (BBC letterto G4S) which at p.8, lines 12-14 reiterates this, SXP00014, your statement to the police andSXP000053 at paragraph 9. aa. Can you recall anything about this incident? Do you recall whether you were awarethat DCO Sanders was present or involved in any UoF incident or other incident on this date? Please give as much detail as possible.	D1527 is traumatised from his time detained at IRC Brook House and cannot remember many details of this incident. According to the PSU it is thought likely that it occurred during the afternoon of 24 April 2017, when DCO Kelvin Saunders was on duty making constant observations of D1527, but it is also possible it happened on 9 April. At 15.52 DCO Saunders records D1527 banging his head against the base of his bed and that DCO Saunders entered the room. The banging continued until at least 16.16, alongside attempts to self-strangulate. DCO Saunders did not make a use of force report for this incident. There is a possibility he may have been involved in the use of force against D1527 on 4 May 2017, which if correct means he did not write up a use of force report for that incident either. The transcript KENCOV1015 – V2017050900016 CLIP3 records DCO Sanders saying on Tuesday 9 May 2017: "We done CMR [C+R?] on him – remember when he jumped on the nettings? Did you hear about that?... Thursday [4 May 2017]". This suggests he may have been involved This allegation for the 24 April 2017 incident was found to be more likely than not to have occurred in the report completed by the PSU

		(CJS001107): *"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."* Extract from Paragraph 7.20. The BBC transcripts have revealed further abuse language used by DCO Sanders against D1527 <u>KENCOV1015 – V2017050900016 CLIP3 (9 May 2017):</u> • "He's a right dickhead" • "He's a fucking kiddy fiddler, man" There is evidence in this transcript that alongside other officers, DCO Sanders is reviewing D1527 security file – which records offences for which were dropped and have no bearing on his actual risk – in public with other officers and making judgments on D1527 accordingly.
<u>25 April 2017 - recorded UoF incident</u>		
44.	Please consider documents CJS005534, CJS000894, CJS000899, SXP000145, CPS000017, SXP000149, and CJS004316. These documents are "Use of Force" forms written by several officers about an incident recorded at 19:09 hours, a G4S spreadsheet, Handover logs, your witness statement, nurse	D1527 has set out in his statement his current recollections and summarised some of his previous evidence. He also provided details in relation to this incident in this witness statement to the police dated 11 December 2017 (SXP000145), in which he stated:

	Mariola Makucka's witness statement, DCO Steve Loughton's witness statement and an incident report regarding a recorded UoF incident on 25 April 2017. bb. Is the officer's account of what happened accurate? If not, please give your account in detail. cc. Were de-escalation tactics used (other techniques before force was used against you; i.e. verbal reasoning)? dd. Were you asked to fill out a form where you could give your account of what happened (called a "de-brief" form)? ee. Was the use of force reasonable in your view? If not, why not? ff. Do you agree that the reason given for using force was correct; preventing injury to an officer and preventing self-harm? gg. Did you sustain any injuries? If so, how were they treated? i. Please consider the healthcare report on the UoF Form: (CJS005534) which says there was slight redness noted on your neck and the statement from nurse Mariola Makucka	*"I cannot say the exact date but from working out other events that happened I believe that on the 25th April 2017 I was in my room which is towards the end near the block, on E Wing and feeling very low so I cut the t shirt I was wearing and tied it around my neck because I felt that I did not want to live anymore. I was near the toilet in the room because I was hiding a bit from the person watching me. I do not remember how, but I ended up in the middle of the room, there seemed to be many hands and force being used on me, I remember an officer cutting the t shirt off with a knife or something like that. I was having flashbacks and I am not thinking about what people are doing or saying. I saw myself back in Egypt and I cannot remember properly what is going on the time. I remember lots of talking and swearing but who was there and what actually was said, I cannot remember.* *After they had removed the t-shirt from my neck they placed me on the floor in the middle of the room, they used a lot of force to do this. I was on the floor for a few minutes, not sure exactly how long I was there for. I then moved and sat down, I then got up and moved around the room. I don't remember much about putting the battery in my mouth, the battery came from the mobile phone I had been given by Brook House, I remember the battery being in my mouth, I do not know why I put the battery in my mouth, no one else would have done it, I do not know if it was this time, but a battery was taken out of my mouth using force at some stage. I think I have attempted to swallow a battery 2 times whilst in brook house."* <u>Unreasonable Use of Force</u>

	(CJS000017) which records "*redness mark on both sides of neck but the skin was in tact"* (p.2), while the G4S spreadsheet (CJS000894) records no injuries. hh. Did any other detainee witness this incident? If so, who?	The use of force against D1527 was unreasonable. It went beyond what was necessary to remove the ligature from D1527 should not have been dragged out of the toilet area once the ligature was removed. D1527 could have been injured as a result. <u>Derogatory remarks</u> In the Callum Tulley footage (V2017042500020), there is evidence that the officers and other staff present were insufficiently concerned about the possibility of D1527 swallowing the battery or choking on the battery. DCO Loughton, who was Oscar 1 that day, describes D1527 as a "cock" (7.06). DCO Nathan Ring makes several remarks about D1527 being a "Duracell bunny" while the battery remains in D1527 mouth (7.18, 12.42 and 14.15). An unidentified member of staff remarks that "Bellend might be off my wing (10.00). <u>Lack of Concern about Battery</u> The records created by the officers do not record the use of force to remove the battery from D1527 mouth. There is no account provided of the battery leaving D1527 mouth. DCO Loughton's statement (SXP000149) states that the battery must have left his mouth otherwise DCO Loughton would not have left the room, but there is no evidence provided from the other staff members about what happened to the battery. These comments were all made in the vicinity of or immediately outside D1527 room and are clearly audible in the footage, which

		suggests that D1527 would have been able to hear them from his position on the bed. <u>General Lack of Concern for D1527 welfare</u> It is apparent from the video footage that D1527 is having a mental health crisis and is severely unwell, but the officers present do not appear to be equipped with any training or understanding how to address such an incident. They also do not show him any empathy and repeatedly express their frustration with him. DCO Loughton complains about "sitting around all flipping night" and tells D1527 that his behaviour will not lead to him being moved to a different wing (5.10). It was inappropriate and insensitive to make D1527 who had attempted suicide moments before, feel like he was making a nuisance or otherwise causing a problem. The comment by an unidentified member of staff that D1527 might be moved off the wing ("Bellend might be off my wing" (10.00)).
45.	In your statement to the police, which is at SXP000145, you state that on 25 April 2017, youwere in your room and were feeling very low so tied a t-shirt around your neck. A lot of force was used to get you to the middle of the floor and the t-shirt away from you (ibid.). You don'tremember putting a phone battery in your mouth but it was taken out at some stage using force. You attempted to swallow a phone battery twice at BH	D1527 has prepared a further witness statement which summarises his previous statements, what he told medics, and adds any further recollections. D1527 also provided an account when making his statement to the police. Additional information can be obtained by watching the Callum Tulley footage of the incident. <u>Inadequate Healthcare response</u>

	(p.1-2.). ii. Do you have anything more to add to your account of this incident?	Healthcare should have raised the alarm about D1527 suicide attempt by issuing a Rule 35(2) report (see answer to Question 50). Please see D1527's witness statement at paragraphs 49- 61.
25 April 2017 - UoF incident		
46.	Please consider the following documents: CPS000002, CPS000003, CPS000004, SXP000145, SXP000120, SXP00149, SXP000126, SXP000120, SXP000145, SXP000044, SXP000051, SXP000053, SXP000065, SXP000100, SXP000105, CPS000026 and SXP000136: (Three reports of Jon Collier, your statement, a statement by Callum Tulley, a statement by Steve Loughton, an interview with Yan Paschali, a record of interview with Yan Paschali, pre-interview disclosure for Paschali, statement notes for Callum Tulley, statement notes for you , handwritten notes regarding an investigation, correspondence between police and the Home Office, police decision on offences, a record of a meeting with Jo Buss, a police report to CPS for charging decision, a record of a meeting with DCO Charlie Francis, a letter from the BBC and a statement by Carrie Dance-Jones). jj. Please describe the incident in your own words. You may find it of assistance to refer to SXP000145 (a statement you made in December 2017 which describes afurther incident on 25 April	D1527 has described this incident in his witness statement at … The Callum Tulley footage (V2017042500021) shows D1527 being choked by Yan Paschali. Several other officers are in the room but apart from Callum Tulley no one attempts to intervene. After the incident the officers and the nurse make an agreement not to complete the necessary Use of Force paperwork. The key incidents in the video footage are as follows: • Yan Paschali chokes D1527 (8.23) • While choking D1527, Yan Paschali says "You fucking (inaudible), you fucking piece of shit because I'm going to put you to fucking sleep." (8.30) • D1527 is obviously in distress and then complains about the pressure being put on his neck (9.10) • When moving D1527 into a different position, Yan Paschali pulls D1527 left arm up behind his back (14.00)

	2017.) kk. Document SXP000120, at pg 4 records that you were seen headbutting the glasspanel, and Clayton was not doing or saying much, just watching. Do you remember doing this? Do you remember Clayton's actions? ll. Do you recall which officers were present? mm. Was there any communication between the officers? nn. Were de-escalation tactics used (other techniques before force was used against you; i.e. verbal reasoning?) oo. Did you hear officers saying anything regarding recording this incident as a Use ofForce event? pp. Were you asked to fill out a form where you could give your account of whathappened (called a "de-brief" form)? qq. Did you have a phone battery in your mouth? rr. Yan Paschali also states that you smoked together and you apologised to him laterin the day and gave him a hug (CPS000019) and shook his hand	• Once the officers begin to release D1527 he makes no attempt to strike the officers, indicating that there was no need to restrain him (15.40). After the incident occurred, the footage records Yan Paschali telling Callum Tulley that there was no need to complete a use of force report about what occurred (25.30). Callum Tulley accepts this. Callum Tulley tells Nurse Jo Buss that Yan Paschali has told him not to complete a use of force report and Jo Buss explains that she will complete the medical observation notes without mentioning the use of force and appears to recognise that to do so would be deliberately misleading (27.26). Later footage (TRN000003 - KENCOV1007 – V2017042500023) notes Yan Paschali stating about the incident: "cracked him on in the ribs to soften him up, that's what you've got to do" During the incident there are numerous occasions in which staff make derogatory remarks about **D1527** • Jo Buss says about D1527 "*he's an arse basically*" (1.49) • When D1527 has a battery in his mouth, Nathan Ring says "*So he wants to use it as his dummy, fine, I'm okay with that*" (6.24) • While Yan Paschali is choking D1527 Charlie Francis says to **D1527** "*you going to stop being a tool, you going to stop being an idiot*" (9.01) • Later, Charlie Francis says to D1527 "*what are you a man or a mouse*" (12.34)

	(SXP000127). Isthat correct? ss. What was your relationship like with Yan Pascali? tt. Was the use of force reasonable in your view? If not, why not? uu. Were you injured? If so, what were your injuries? You may wish to refer to CJS001085 at pg 19. vv. Did you see Healthcare? Did they provide you with any treatment? i. Please consider HOM000195, pg 97. You state that this was the only occasion on which you saw a doctor on E-Wing. Is that correct? Were there other occasions on E-wing where you wanted to see a doctor but could not? ww. Did any other detainee witness this incident? If so, who? xx. Please consider CPS00026 at p.9, lines 10-12, in which DCO Charlie Francis is recorded as saying "we're getting bored with this, are you a man or a mouse, comeon stop being a baby", and p,10, lines 29-33 in which DCM Ring is recorded as stating that you would "start bouncing around like a Duracell bunny" and other similar comments. Do	• Yan Paschali says that D1527 is "full of shit" (16.00) There was no attempt to de-escalate the situation before the use of force and D1527 was not provided with a de-brief form. The only officer who objected to this mistreatment of D1527 was Callum Tulley, although even he continued to restrain D1527 during the incident. The use of force was unreasonable, unnecessary and completely outside the scope of legitimate use of force, as confirmed by the three reports produced by Johnathan Collier. Callum Tulley also states in his witness statement that he was concerned Yan Paschali would kill D1527 by strangulation. D1527 did not apologise to Yan Paschali after the incident. Any compliant behaviour towards Yan Paschali after the incident would have been the result of fear of a further assault. Pp: As to "de-brief" see para 51. As to the incident- see paragraphs 50-61 of the WS Nn: As to de-escalation, see para 75 of his WS. As to injuries, see para 56. Ss: as to Yan Paschali- see WS para 54-5 Vv: As to healthcare, see WS para 60

	you remember this incident? Can you add any more detail?	
4 May 2017 - recorded UoF incident 4 May 2017 - recorded UoF incident		
47.	Please consider CJS005530, CJS000897 and CPS000026, which are a "Use of Force" formwritten by several officers about an incident, G4S spreadsheet, letter from Panorama and Handover logs re UoF on 4 May 2017. a) Is the officer's account of what happened accurate? If not, please give your account in detail. b) Were de-escalation tactics used (other techniques before force was used against you; i. i.e. verbal reasoning)? c) Were you asked to fill out a form where you could give your account of what happened(called a "de-brief" form)? d) Was the use of force reasonable in your view? If not, why not? e) Is it correct that you were seen by Healthcare? Did you	D1527 has given his account of this incident in his witness statement at paras 68-80. D1527 position is that force used against him was unlawful and an assault because he was not lawfully detained (so trespass against his person was accordingly all unlawful). But regardless of that, the use of force was entirely unjustified, unnecessary, unlawful and constituted an assault. The force to transfer D1527 to E-wing was done pursuant to an unlawful decision to segregate under Rule 40 (see response to question 66 below). The actions of officers, primarily the supervising officer DCM Dix, only served to unnecessarily escalate events and cause distress to a highly vulnerable and suicidal detainee. There were significant failings in the investigation of his complaint of assault by the PSU who did not even interview the main perpetrator, DCM Steve Dix. The Inquiry asks if the officers' account of what happened are accurate. They cannot be accurate as the reports of the four officers all wholly inconsistent with each other. CCTV confirms a fifth officer was also present in the room (DCO Ben Wright) (Disk 41 05 May 2017 1727). An as yet unidentified sixth officer is standing outside the cell watching the force being applied. Neither of these two officers produced a use of force report, or at least a security incident report to confirm what they

	sustain any injuries? i. Please consider the Healthcare report on the UoF Form (CJS005530) which records a small scratch to left wrist and the G4S spreadsheet (CJS000897)which records no injuries. f) Do you agree that the reason given for using force was correct: namely non- compliance/prevent self-harm/prevent injury to another? g) Did any other detainee witness this incident? If so, who?	witnessed. The inconsistencies and the history of the officers, combined with the plainly unjustified Rule 40 decision, the lack of body-cam footage (despite there being a plan to move D1527 to segregation), and the failure of two officers involved to write up reports mean that the officers' accounts cannot be accepted or relied upon. DCM Dix was already found by G4S to have made failures as a DCM to investigate and properly follow up on the assault against D1527 on 25 April (CJS004302_0005) and was captured by Panorama footage, in the build up to the use of force against D1527 on 4 May, giving entirely unsympathetic and highly offensive comments about D1527 and his suicide risk ("oh well"). **Planned Incident** Contrary to the claims of DCM Dix, all evidence suggests that this was a planned incident in which force could have been reasonably foreseeable or sufficiently anticipated. Alternatively, it should have been properly planned.This is because: • DCM Dix had made the decision to use Rule 40 against D1527 and transfer him to E-wing or CSU prior to entering the cell. His report anticipated that force would be used if he refused ("I explained if he refused then potentially as a consequence of his actions force could be used") – this is something DCM Dix knew from the outset. Dix was clearly aware of D1527 self-harm history and that he may not agree to go to E-wing – a location in which his vulnerabilities and suicide risk had previously been wholly mismanaged to D1527 significant detriment.

		• DCM Dix's report confirms that healthcare were present throughout the incident – RMN Karen Churcher (CJS005530_0005). G4S' Use of Force guidance (March 2016) confirms healthcare are present when use of force is planned: see 6.3: "*Inform Health Care staff, and ensure that at least a nurse is present during the briefing, the use of force and any relocation process*" and 8: *"A member of health care staff must, wherever reasonably practicable, attend every incident where there is a potential that force maybe used on any detainees. Health Care staff will stay in attendance until the detainee has been relocated or handed over to the escorting staff."* (CJS000360). • CCTV shows 6 officers present during the use of force – DCM Dix, as Oscar 1, and DCO Michael Yates are in D1527 cell first, before being joined by DCOs Ryan Bromley, Michael Shaukat and Ben Wright. A Sixth officer is outside the cell watching at all times. DCM Dix having five officers on stand-by clearly indicates that force was anticipated and that this should have been a planned incident. The reason it is important to note whether it was a planned incident was because: (a) it casts serious doubt over DCM Dix's claims that the force was unexpected, spontaneous and done to protect officers/prevent self-harm; and (b) because the incident should have been filmed by BWC or hand-held camcorder from the outset. If that had occurred, there would have been footage inside the D-wing cell in which force was first used against D1527 That CCTV and BWC later picked up footage later into the transfer does not assist here – it is the

		initial incident that supposedly justifies the use of force to transfer that is relevant and should have been filmed. This is where D1527 claims he was ultimately assaulted in that the force used by officers was unjustified, unnecessary and disproportionate. The PSU report at 7.87 confirms neither DCM Dix nor Yates wore a BWC and that in April 2017, the use of BWCs were "not obligatory" and there were not enough cameras for all managers to have them. The PSU still recorded that it would he been "useful for a handheld camera, or a BWC to have been used from that point to capture the full incident and the audio" (CJS001107). All use of force reports disclosed by the Inquiry for 'planned' control and restraint incidents show that cameras were used. There is no possible explanation as to why DCM Dix should not have known this or why he could not have followed policy – the PSU report confirms that the "unsatisfactory recordings" in this incident were "managers not following the policy". A handheld camera at the very least should have been on the scene. DCM Dix's failures to ensure the conversation with D1527 in the D-wing cell was filmed undermine his evidence – and that of the other officers - and suggest he did not approach the incident with a level of care and professionalism. His lack of care about **D1527** well-being is documented by his comments ("oh well") about D1527 jumping off the netting. DCM Dix's evidence must be considered through this prism and his evidence given limited weight. **Claimed Justification for Force**

		DCM Dix has recorded the reasons for use of force being 'Non-compliance/present self-harm/ injure third party' (CJS005530_0001) 'Non-compliance' - The transfer to E-wing/CSU was required on the basis of an unlawful and unnecessary decision to use Rule 40 against D1527. DCM Dix states that D1527 said 'no' when asked to transfer to Rule 40 and therefore he told him "*if he refused then potentially as a consequence of his actions force would be used*". It is unclear what attempts DCM Dix would have then gone on to 'de-escalate' the situation as he then claims that spontaneous force was immediately required after this for reasons of self-harm/risk to own safety. DCM Dix states: "At this moment he placed his hands in his pocket looking like he was trying to access something, I asked him to empty his pockets and remove his hands he refused to do this. For this reason I felt fearful for his safety as he has a history of self harm but also fearful for my own safety so spontaneous force was required to prevent a possible weapon being produced." **This is ultimately DCM Dix's justification for spontaneous force and is based entirely on the perceived risk in not knowing what D1527 might have in his pocket, what he might do with it if he was able to retrieve it and whether it was proportionate or reasonable to think that D1527 would use the unknown item as a weapon against himself or officers. This however appears entirely speculative by DCM Dix and not proportionate to the risk as presented. D1527 does not have a history of assaulting officers. And more importantly the reports of the other officers contradict DCM Dix's account and show that any item in D1527 pocket was not unknown.**

		Conflicting Accounts of Officers • **DCM Dix:** As stated above, DCM Dix claims that D1527 placed his hands in his pocket, Dix asked him to empty his pockets and he refused. Force was therefore immediately used by Dix by controlling D1527 right-arm, getting it into a back-hammer before handing over to DCO Yates once officers came to assist. • **DCO Yates**: *"Once in the room DCM Dix began talking to Mr D1527 about what had happened and explaining that we would need D1527 to escort us down to Eden wing until the matter had been fully investigated. At the point Mr D1527 said something along the lines of "Go get your friends to get me I am not going anywhere". At this point Mr D1527 put his right hand in to his pocket and looked to be reaching for something. DCM Dix asked Mr D1527 what was in his pocket and asked Mr D1527 to remove his hands from his pocket and place them by his side. Mr D1527 responded with "You'll see what is in my pocket" he then stood up with his fists clenched and started shouting. DCM Dix then grabbed hold of Mr D1527 right hand. At this point DCO Bromley and DCO Sheharyar Shaukat entered the room and began to restrain Mr D1527. I took the right arm of Mr D1527 and isolated his arm to the small of his back."* (CJS005530_0018) **This is plainly inconsistent and undermines DCM Dix's justification because:**

		○ Yates adds that D1527 was telling Dix to get 'his friends' (i.e. the officers outside) when Dix only says D1527 said 'no' in response to walking compliantly ○ Yates claims that in response to Dix asking D1527 to empty his pockets, D1527 says: *"You'll see what is in my pocket"* and that he then *"stood up with his fists clenched and started shouting"* – This is entirely inconsistent with Dix. Dix states D1527 refused to show what was in his pocket and refused to remove his hands from his pocket and so Dix used force immediately against D1527 without D1527 doing or saying anything further. Yates's comment suggests D1527 was threatening officers with what is in his pocket, before clenching his fists and appearing like he was about to attack the officers. ○ Yates suggests Dix took hold of D1527 right hand (Dix says he took hold of right arm before putting into back-hammer then handing over to Yates) then Bromley/Shaukat came in and restrained D1527 before Yates took the right arm and isolated it to his back. Dix suggests he handed D1527 over to Yates before the other officers were involved. This is all entirely inconsistent and out of order • **DCO Shaukat:** *"At Approximately 17:23 I DCO Shaukat and DCO Bromley entered the room, due to the loud aggressive tone Mr D1527 was using towards DCM Dix. DCM Mr .Steve Dix asked Mr D1527 for his cooperation on more than one*

		occasion. Mr D1527 was not willing to cooperate he then stood up from the bed he was sitting on in an aggressive manor with both fists closed and tried to reach for his right pocket while trying to swallow his phone which then fell off. I... then took control of Mr D1527 head inside the room. Officer two and three then took control of Mr D1527 right and left arm, as soon as they had locks on." (CJS005530_0011) **Again this version of events cannot be reconciled with DCM Dix's statement or Yates:** ○ Shaukat confirms he and Bromley entered the cell whilst negotiations wre still going on because D1527 was said to have a "loud aggressive tone". Dix says they arrived after he initiated force (*"before handing it over to DCO M Yates once officers came to assist"*). ○ Shaukat says D1527 stood up off bed in aggressive manner with both fists closed and trying to swallow his phone. Again Dix does not mention D1527 being aggressive with his fists closed, Dix says hands were in pocket and refusing to show what it was. Shaukat suggests that D1527 may have been reaching for his phone and was trying to swallow it. If the item was clearly a phone this significantly undermines Dix's justification for force which is based entirely on not knowing what D1527 had and that it could be used to hurt D1527 or officers. ○ Shaukat's account suggests he took force first by taking hold of D1527 hands before officers two and

		three (Yates and Bromley) took D1527 arms – there is no suggestion that Dix took hold of D1527 first • **DCO Bromley**: *". At approximately 17:23 myself and DCO Shaukat entered the detainees room following hearing detainee D1527 aggressively shouting, upon entering detainee D1527 reached for his right pocket while trying to swallow his phone to which he didn't succeed and instead he dropped it onto the floor in the room by mistake. Immediately D1527 stood up from sitting on the bed in an aggressive manor with both fists closed insulting DCM DIX, and then reached for the phone for the second time. At this point DCO Shaukat took control on detainee D1527 head while myself took control of his left arm and DCM Michael Yates took control of his right arm*". (CJS005530_0014) **Again this is entirely inconsistent with Dix's account:** ○ Like Shaukat, Bromley suggests he and Shaukat entered the following because D1527 was "aggressively shouting" and before Dix applied force. ○ Bromley states D1527 reached for his right pocket whilst trying to swallow his phone, did not succeed and instead dropped the phone. He then got off the bed "*in an aggressive manor with both fists closed insulting DCM Dix and then reached for the phone the second time*". This again cannot be reconciled with Dix's account and undermines the entire justification that

		Dix did not know what D1527 had in his pocket and so used force before D1527 could use it in case it was dangerous. Bromley and Shaukat's accounts suggest that the item was a phone, that he had gotten it out of his pocket and that Dix did not spontaneously use force on basis D1527 had hands in his pockets. o Bromley confirms Shaukat took hold of D1527 head first before he and Yates took the arms. He does not state Dix initiated the force then handed him over to Yates then the other officers. • **All officers**: There is no reference in any of the reports about DCO Shaukat having his hands around D1527 neck area at the doorway of D-wing. There is no approved technique that would justify this unlawful use of force and no mention of the force in the use of force reports. See further section below - **Possible Additional Assault Revealed by the CCTV by DCO Shaukat** These reports are entirely inconsistent, cannot be reconciled with each other and the reports of Yates, Bromley and Shaukat entirely undermine Dix's claimed justification for spontaneous force in the interests of the safety of D1527 and officers. CCTV shows that around 5:41pm that DCM Dix and DCOs Yates, Shaukat, Bromley and Wright spend significant amount of time talking outside D1527 cell after transferring him to E-wing (Disk 41

		05 May 2017 1727). Questions must be asked about the extent to which the incident was de-briefed and whether attempts were made to decide on a version of events before writing the reports. Regardless, it is clear the reports do not match up and evidence of the officers cannot be relied upon – particularly when combined with the fact that DCM Dix failed to have a camera for this planned incident and where the underlying segregation decision was unlawful. There are serious questions for the PSU in their investigation of this incident, particularly their conclusions at 7.89 and 7.91 in which the investigating officers found the four detention officers to have given consistent accounts and that "*There was no evidence that excessive force was used, or that staff were unprofessional during the use of force.*" (CJS001107_0030). The accounts were left untested with only DCO Yates being interviewed. DCM Dix, and DCOs Bromley and Shaukat were not interviewed. The PSU reports notes at 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"* These reasons for not interviewing DCM Dix are plainly inadequate. He was the Oscar 1 and supervising officer for the incident. His report may have had 'sufficient detail' but the inconsistencies with the other reports meant DCM Dix should have been interviewed and the

		inconsistencies put to him. Equally it was not justified to say there was video footage of the incident – there was only footage of the transfer, not the initiation of force in D-wing which is the main complaint in respect of the force used. In addition the PSU failed to identify the other officers present. **<u>Other Officers Present</u>** Not only are there concerns about the conflicting accounts of the four officers who completed report, but the evidence suggests there were two other officers present who failed to write up any report and for whom Dix, Yates, Shaukat and Bromley all fail to reference were present during the restraint. CCTV (Disk 41 05 May 2017 1727) confirms that two other officers were present during the force used against D1527 in the D-wing cell. We have been able to identify who we believe is DCO Ben Wright from the CCTV footage. At 17:23pm (31:52mins into the CCTV clip) the CCTV shows four officers (Bromley, Shaukat, Wright and a further officer) all stood outside the D-wing cell – Dix and Yates are already in the cell at this point. Three officers enter the cell in turn – Bromley then Wright then Shaukat. The other officer stands outside looking into the open cell watching events. A few seconds after Shaukat enters, Wright briefly comes to the door – says something to the unidentified 6th officer and points down the corridor, before re-entering the cell. The 6th officer continues to stand

		outside the cell looking in and appears to take no action based on what Wright says to him. At 17:25pm (33:20minutes) one of the officers from inside the room (unclear who) can be seen passing something to the unidentified 6th officer. It's unclear from the quality of the footage if he keeps hold of the item or puts it in his pocket. It is unclear what the item is, e.g. whether it might be D1527 phone. When the officers leave the cell, DCO Wright is not holding D1527 but is facing towards him and watching him the whole way whilst the unknown 6th officer talks in front. The officer can be seen throughout the incident and in taking D1527 to E-wing and staying on E-wing whilst DCM Dix appears to de-brief the officers outside D1527 E-wing cell. Neither officer has produced a use of force report and neither officer is mentioned in the use of force reports of Dix, Yates, Shaukat and Bromley. G4S' use of force policy dated March 2016 (CJS000360) states at section 9: "*All members of staff who were involving in using physical force will record exactly what their involvement was on the Annex A of the Use of Force report form. Any members of staff who witnessed the use of force incident will be instructed to complete an incident report; which will be submitted to the Use of Force Supervisor.*"

		If DCO Wright or the 6th officer used force at any point, they should have completed a use of force report. It is unclear if DCO Wright was involved in the force in the D-wing cell but it is concerning that his presence is not referenced by other officers. What is clear is that at the very least DCO Wright and the 6th officer should have completed incident reports as witnesses to the force used by the other officers. These reports cannot be located on Relativity and there are therefore doubts that any reports have been completed by DCO Wright or the 6th officer. There are no references to such reports in the PSU investigation (nor any reference to the officers despite the CCTV having been viewed) The only incident report is completed by DCM Dix (HOM000319). Neither DCO Wright nor the 6th officer are mentioned in this incident report. The report is blank on the list of "staff witness(s)" (HOM000319_001). The Inquiry needs to urgently investigate DCO Wright and the 6th officer's role in the incidents of 4 May 2017, why they did not write up reports, and why they were not mentioned in the reports of the other officers. The Inquiry needs to urgently identify the 6th officer. **Mental Health Risks** As set out in response to question 66, the actions by officers on 4 May 2017 took no account of D1527 vulnerabilities and his unsuitability to be segregated or managed in E-wing where he was previously repeatedly assaulted on 24-25 April 2017. The evidence suggests DCM Dix approached the aftermath of D1527 being on the netting with no sympathy or regard to D1527 vulnerabilities, his self-harm/suicide

		risk. No attempt was made to work out why D1527 may have been the netting in the first place and how it was likely an acute mental health crisis. This complete lack of care or sympathy for a vulnerable individual in his care is reflected by DCM Dix's comments in response to Callum Tulley's concerns that MA might attempt to jump off the suicide netting - **"Oh well, its his own choice innit"** (KENCOV1012 – V201705040022 clip 2) The healthcare oversight was led by mental health nurse Karen Churcher. We have set out concerns in more detail below in response to question 66 which are equally applicable here. However what is key is that Karen Churcher, as D1527 mental health nurse, knew better than most others the extent of D1527 vulnerabilities – she was present when he was diagnosed with PTSD just two days earlier. She had repeatedly been told by D1527 that he had plans to kill himself. She should have known that D1527 being on the netting was about more than just a 'dirty plate' yet she laughed along with other officers in claiming he was overreacting ("If he didn't have to do the washing up, he didn't have to go that far did he… I don't know (laughing) it's a dirty plate")- KENCOV1012 – V201705040022 clip 2. She was responsible for D1527 clinical care during the use of force incidents and did nothing to suggest she was looking out for the best interests of her patient. **Comments from Transcripts on 4 May 2017 incident** In addition to the above, the wider BBC transcripts that have been released provide additional evidence that the force used against D1527 on 4 May 2017 was unlawful. At the very least officers appeared to

		be laughing at D1527 expense during the netting incident, and then showing little sympathy to the force used against D1527 subsequently by DCM Dix and his team: <u>Laughing/lacking sympathy at D1527 being on the netting:</u> • Precious Okolie Nwokeji: [inaudible] **a bitch because he was told about a plate (**<u>KENCOV1012 – V201705040021</u> • Officers failing to challenge Detainee 1 singing 'I believe I can fly' regarding the fact D1527 might jump and try commit suicide (KENCOV1012 – V201705040022) • Clayton Fraser when asked about the best way to deal with D1527: "**What Yan did (laughs**)" (KENCOV1012 – V201705040022 clip 2) • Steve Dix: "**Oh well, its his own choice innit**" (regarding risk of D1527 jumping off netting) (KENCOV1012 – V201705040022 clip 2) • Karen Churcher: **If he didn't have to do the washing up, he didn't have to go that far did he… I don't know (laughing) it's a dirty plate** (KENCOV1012 – V201705040022 clip 2) <u>Discussions that force used on 4 May 2017 was unlawful/disproportionate:</u> • Ryan Bromley to Callum Tulley: "**Got bent up and Mike's put him on E wing**". Tulley: "You had to bend him up?" Bromley: "Yeah, me, Mo and Dixon." (KENCOV1012-V201705040025)

		• Kalvin Sanders to Callum Tulley: "We done CMR (C+R?) on him on – remember when he jumped on the nettings… **He was crying after it… he's a right dickhead** (KENCOV1015 – V2017050900016 CLIP3) • Kalvin Sanders and Aaron Stokes on 4 May 2017 both discuss D1527 – likely speaking about him given the use of force against him that day – in the Panorama documentary: o DCO Kalvin Sanders in staff room to Callum Tulley and other officers retelling D1527 incident above again: "**He's been a right prick, and he's trying to do that to his neck. So when he had that, I fucking went like that and like that**." (23:22mins) o DCO Aaron Stokes in same staff room conversation as above when asked by Callum Tulley on the best way to deal with D1527: "**Turn away and hopefully he's swinging, probably**" (23:37 mins • Callum Tulley video diary (BBC000601 – KENCOV3019): "*I get on with Ryan, we have some interesting conversations. So I went out with him and basically just asked him what happened with* **D1527** *you know, "Did they have to restrain him?". And he said they had to bend him up. At first only guiding hold, but then when he got down to solitary confinement he started to kick off. And then they had to restrain him again fully.* • *There wasn't anything that Ryan said to me that indicated that anything like what had happened with Yan the previous week*

		happened. ***But there was another officer, Aaron, who seemed to suggest that… he did say something that suggested to me when they went into the cell and there were no cameras that maybe something untoward might have happened***" • Callum Tulley video diary (BBC00629 – KENOV3058) on 20 June 2017: *": [Talking about Ryan Bromley – assume 4/5/17 incident] But* ***more recently I've heard that this officer might have been involved in potential further abuse of*** D1527 *I've heard… In fact, I've seen him agree to cover up instances of self-harm so that detainees don't have to go under constant supervision. I've seen him participate in a conversation where he's referred to officers who would assist Sean in covering up an assault as a good team. I'm seeing this transition from a fresh officer who's working hard to do his job, who gets in the middle of fights, and who you'd imagine would be pretty downbeat about the way his new job's going. As a result, I'm worries that I've just see him slowly… How do I word this? …. I'm worried that Ryan has already become corrupted by Brook House; he's already changed for the worse and he's not even been there that long."* **Possible Additional Assault Revealed by the CCTV by DCO Shaukat**

		There are concerns that D1527 have been subjected to a further assault/use of force by DCO Shaukat. The relates to this incident described by the PSU: *"7.83. 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"* This incident appears to occur at the doorway out of D-wing and is not mentioned by DCM Dix, DCO Bromley nor DCO Shaukat in their report despite all being present. DCO Yates is the only officer who mentions a struggle and force being used at this point: *"We left the room and began walking.to the back exit on level one of Dove Wing. Just before leaving the wing Mr D1527 began struggling and pushed his way to the Wall. After a struggle I applied the thumb flexion/lock back onto Mr D1527 We then moved forward and made our way to Eden Wing."* As the PSU states, the entire incident cannot be seen on the CCTV. However what can be seen at 17:26pm (34:49 minutes into the CCTV

		clip) is that DCO Shaukat's hands are raised towards D1527. The PSU describe Shaukat as holding his head, **yet Shaukat's hands can clearly be seen at D1527 neck area**. DCM Dix, DCO Wright and the 6th unknown officer all have a clear view. DCO Bromley can be seen to be right behind D1527 (he is notably taller that D1527). D1527 then appears to fall back through the door at the impact of Shaukat's force. Shaukat then appears to be leaning down holding something or someone (presumably D1527) on the other side of the door. DCO Shaukat goes through the door back into D-wing followed by Dix with Wright and the unknown 6th officer waiting at the door. At 17:27, D1527 is brought back through the door with Shaukat holding his head and Yates/Bromley holding his arms. **Irrelevant/DPA**

Irrelevant/DPA

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

> *"11... The footage clearly shows the hand position around the neck of detainee D1527 and the thumbs of DCO Paschali being driven into the neck/throat area.*
>
> *12. There is a technique taught to staff known as the Mandibular Angle Technique (MAT). It is used as a pain-inducing technique for use in circumstances where other techniques are proving ineffective or if the risk of harm is so*

		great immediate action is required. Prior to any pain-inducing technique being applied staff should where possible, engage in verbal reasoning, inform the detainee of what is expected of them, warn the detainee and attempt to manage the situation without applying pain. If pain is applied it should not be for any longer than five seconds, although some circumstances may dictate longer. The application of this technique requires pressure to be exerted by the thumb through the point at the base of the earlobe. The technique used by DCO Paschali does not reflect the MAT and it can in no way be interpreted as attempting to apply the MAT. The pressure used by DCO Paschali was more to the centre of the neck and appeared to be either side of the windpipe." This advice should also be applied to this instance with DCO Shaukat. DCO Shaukat's hands can be seen around D1527 neck. There is no force that would justify Shaukat taking D1527 neck. If Shaukat is in fact using the MAT then (a) the justification for its use cannot be made out on Jon Collier's guidance above, and (b) Shaukat has entirely failed to set out this incident in his report without any justification. An MAT appears to be a technique of absolute last resort –this clearly cannot be made out where D1527 is still under control from Yates and Bromley and there are 6 officers present to manage the risk. Yates has accounted for his force but there are questions as to whether pain-inducing techniques that he applies are proportionate or necessary to someone with D1527 vulnerabilities, and certainly where he should not be going to E-wing in the first place. Shaukat has clearly

		applied some further force, at least in the doorway – but his holding of D1527 head throughout the incident needs to be carefully reviewed -, but neither he, nor Bromley or Dix records this incident. There are concerns that Shaukat could have grabbed D1527 neck. Regardless this instance of force should have been recorded by Shaukat (and Bromley and Dix) but was not. This is a significant failing by the officers that further undermine their evidence. The Inquiry need to urgent investigate this specific aspect of D1527 transfer to E-wing. ***(c)Were you asked to fill out a form where you could give your account of what happened(called a "de-brief" form)?*** D1527 was not asked to fill out a de-brief form ***(g) Did any other detainee witness this incident? If so, who?*** The use of force reports that D1527 went to the cell of D378 and D812 to calm down after the netting incident, after it was agreed with DCM Dix that this was the best way to de-escalate the situation (DCM Dix failed to tell D1527 in negotiations that he would be subject to R40). **Although it is not yet clear the extent of any assault they witnessed, D378 and D812 are key witnesses. We have previously asked the Inquiry to identify and locate these two individuals. We would be grateful for an urgent update on this and confirmation they have been identified.**

48.	Please consider CPS000045, HOM000319, and SXP000057. The latter is a letter from the BBC to G4S stating what was recorded on the footage, which says that on 04 May 2017 (internal p.12, lines 26-30; see also internal p.14, lines 33-36), you stood on anti-suicide netting on C wing and threatened to throw yourself off down adjacent steps. Other detainees were not removed from association and made inappropriate comments like singing "I believe I can fly". You finally left the netting voluntarily but were later restrained in your room, reportedly crying during the use of force. a. Do you have any comment to make or any detail to add in relation to this event?	See D1527 witness statement at paragraphs 60-81 which explains why he was on the anti-suicide netting. Further comments in respect of this incident are addressed in full in response to the question above.
49.	As far as you recall, and save for any incidents you have set out above, was force ever usedagainst you by Brook House staff, i.e. being physically restrained, held, moved, pushed, handcuffed? If so, in relation to each incident (as far as possible): a. Please provide as far as possible details of the time, place and what happened. b. Were de-escalation tactics used (other techniques before force was used	Please see client's witness statement at paragraph 32. D1527 knows that there were more occasions than are revealed in documents when force was used against him, but. D1527 has significant difficulty being able to remember every incident of abuse he suffered at Brook House and the dates they have occurred. He has done his best to provide his recollection. It may be that further instances of abuse begin to emerge throughout this investigation and the Inquiry should inquire into and be mindful of this.

	againstyou; i.e. verbal reasoning)? c. Was the use of force reasonable in your view? If not, why not? d. Do you agree that the reason given for using force was correct (e.g. self-harm orpreventing injury to another)? e. Were you asked to fill out a form where you could give your account of what happened (called a "de-brief" form)? f. Were you injured? If so, what were your injuries? g. Did you see Healthcare? Did they provide you with any treatment? h. Did any other detainee or staff member witness this incident? If so, who?	
	Did you witness any incidents where force was used on another? Please provide details if so. NB this question is wrongly numbered in the Rule 9 question list	D1527 is not able to recall this. It should be noted that recalling his own experiences has consumed a great deal of energy and time from him and we have not sought to address this issue.

	as Q54 provided on 20 August 2021	
Rule 35		
50.	Please consider document CJS001123. This is a Rule 35 report dated 13 April 2017. A doctorhas filled out the report based on his examination of you. *a.* Please set out your understanding of the purpose of this process. *b.* Do you remember this examination? If so, do you have any comment to makeabout how it was conducted? *c.* Looking at Section 4 (Detainee's account). Do you agree that this is a fairsummary of what you told the doctor? *d.* Looking at Section 5 (Relevant clinical observations and findings). Do you agree that these are the scars/physical injuries that were shown to the doctor? *e.* Did your treatment at Brook House change in any way as a result of this report?	See D1527 witness statement at paragraphs 35-38. The purpose of Rule 35 of the Detention Centre Rules 2001 is for doctors make reports to the Secretary of State for the Home Department about vulnerable detainees so she can review whether they should continue to be detained. It operates alongside the 'Adults at Risk in immigration detention' statutory guidance and is designed to provide protection for vulnerable detainees. Home Office policy and the common law prescribe that highly vulnerable detainees should not be detained at all. So if the Secretary of State operated a system where proper consideration was given to individual circumstances, D1527 would have been released well before he was transferred to Brook House. While it is for the Secretary of State to make her own inquiries in relation to this, since not everyone is represented, in D1527 case tthe Secretary of State was put on notice of his vulnerabilities D1527 solicitors before he even reached Brook House (while he was detained in Belmarsh prison). Rule 34(1) of the Detention Centre Rules 2001 requires that in all cases of a person being detained an examination be undertaken within 24 hours of admission to the detention centre. This is for the purpose of producing a rule 35 report, which in the case of any concerns about mental health, suicidality, torture history etc, is to be sent to the

	f. Do you have any other comment to make about this report?	Secretary of State for consideration. The intention is that this acts as an additional safeguard against detaining people who are too vulnerable to be held in detention. I.e. they should not be detained at all, but where they are, the rules build in a safeguard to ensure they can be released within 48 hours. That did not occur in this case. Rule 35 also provides a mechanism for ensuring that a person who should not be detained is brought to the attention of the Secretary of State and released at any point when it becomes apparent in the course of detention that they are in fact vulnerable because of suicide risk, mental health, other medical issues, torture history etc. The importance of Rule 35 as a safeguard is that it should trigger an urgent and automatic review of an individual's suitability for detention. As well as directing reports for those where it is expressly found that their health (including mental health and also physical health) is likely to be injuriously affected by continued detention (R35(1)), reports are also required in areas that the SSHD has decided show an individual is inherently vulnerable to detention – i.e. where they should suicidal intentions (R35(2)) or they may be a victim of torture (R35(3)). Rule 35 should therefore be contrasted with the use of IS91RA Part C forms. An IS91RA Risk assessment is completed at the outset once a decision has been taken that someone is suitable for detention so that the SSHD and IRC staff are aware of any potential risks when managing a detainee. These risk factors are not just health-related but

		will include concerns about past violence/behaviour, criminality and other factors that might inform decisions such as where in the detention estate a detainee should be placed and their suitability for room sharing (see Chapter 55.6.1 EIG). Chapter 55.6.1 confirms that the risk assessment is "an ongoing process" and that should further information become available "which impacts upon potential risk (either increasing or decreasing) during a detainee's detention" then that information should be recorded and forwarded to DEPMU (the Defendant's team responsibility for the management and locating of detainees within the detention estate) using a form "IS91RA Part C". It makes clear that the purpose of an IS91RA Part C is to allow DEPMU to "reassess risk and reallocate detention location as appropriate." Therefore an IS91 RA Part C is <u>not</u> a trigger for a review of the appropriateness of detention, but is about management of a detainee and where they should be located within the detention estate. This is confirmed by Ouseley J in *Medical Justice & Ors v SSHD* [2017] EWHC 2461 who at paragraph 166 found that an IS91RA Part C was not a substitute for a Rule 35 report (in that context, a Rule 35(3) report). D1527 cannot now remember details about the medical examination which took place over 4 years ago. D1527 was severely unwell at the time and has had numerous medical examinations since then. There is no reason to expect that D1527 experience at IRC Brook House would have changed as a result of the Rule 35 report. The purpose of the report is to pass information to the Secretary of State for the Home

		Department rather than to change the conditions in which the detainee is held. The question implies a number of misunderstandings of the report's purpose.
51.	Please consider document HOM000007 which is a response to your Rule 35 report. Do you have any comment to make on the response?	NB the document reference is incorrect. D1527 has commented on the Secretary of State's consideration at paragraph 39 of his statement. The first thing to note is a rule 35 report should- according to the law- have been completed within 24 hours of D1527 being detained: see rule 34(1). Failing that, D1527 should have been released: detention can only be authorised where it is authorised based on a decision in accordance with the stipulated legal process. The Inquiry may wish to inquire why this was not done and why the Secretary of State did not seek to follow up on the absence of a medical examination when authorising detention. Once submitted on 6th April the Secretary of State for the Home Department was legally obliged to have taken into account the psychological report of Tiago Brandao and factored that into whether D1527 should be detained. The starting presumption was always to release: failing proper consideration of whether to detain in light of a proper rule 35 report and in light of the medical evidence that was provided, D1527 should have been released.

		Further, Doctor Oozerally, when he prepared the rule 35 report, should- according to the clear terms of rule 35 and in accordance with the relevant DCOs have reported on whether detention was having an injurious effect on D1527 mental health and suicidality. The Secretary of State, on receiving the report he did was required by his statutory guidance (the AAR policy) to consider the report within 48 hours. She did not do so. Upon reviewing it, she should have realised the report was deficient and should have either released D1527 or, if she was contemplating further detention, should have taken further measures to ascertain whether the presumption against detention could be justified. That would have involved asking the doctor who completed the Rule 35 report to investigate further and reach a decision about whether detention was having a detrimental effect on D1527 mental health. The doctor could have sought further information about D1527 condition in the community and compared it with D1527 clinical history in detention. If the Secretary of State for the Home Department had done this then she would have been alerted to the concerns about the effect of detention on D1527 mental health much earlier. Moreover, the doctor's reference to D1527 having self-harmed in the community is an unsatisfactory reason for failing to conclude that detention would harm D1527. The fact that someone has previously self-harmed in the community makes it more likely that detention will harm their mental health. The Secretary of State for the Home Department should have queried the report and asked the doctor to revise their conclusion.

		D1527 raised these issues with IRC Brook House in correspondence from his solicitors on 13 April 2021.
52.	Please consider document CJS001153, page 2. It is recorded in the caremap that you claimed to have been tortured. Please provide further information on who you spoke to aboutthis and what action was taken.	D1527 cannot remember details about when he asked healthcare to arrange a Rule 35 assessment. However, his statement records the correspondence from Duncan Lewis which sought to ensure that there was such an assessment, It should not be forgotten that this should have been automatic within 24 hours of admission to the detention centre. It is unclear from the document when the comment was added to the care map, but an Rule 35 appointment was booked for 12 April 2017 and a Rule 35 report was produced on 13 April 2017.
53.	Save for the event above, did you on any other occasion see a doctor in relation to the preparation of a 'Rule 35' report?	No. See WS para 66.
54.	If so, what was the outcome of the report? Were you content that the report accurately reflected what had happened to you, and what you had said?	The Rule 35 report failed to accurately capture the scale of D1527 mental health difficulties. See above and D1527 WS 35-41 and 62
55.	Please consider HOM002997, a report written by Dr Thomas dated 31 May 2017 at the request of your solicitors. This was not produced by healthcare at Brook House but commentson your	D1527 agrees with the content of the Dr Thomas report. See further citation from it in his witness statement.

	background, condition and the effect of detention. i. Do you agree with the content of the report? ii. Do you have any further comments to make?	
56.	What other, if any, experiences did you have of the Rule 35 process?	The Rule 35 process was not properly applied to D1527. Rule 35 of the Detention Centre Rules 2001 requires the provision of a report in three circumstances: 1) where the health of a detained person is likely to be injuriously affected by continued detention or any conditions of detention 2) where a detained person is suspected of having suicidal ideations 3) where there are concerns that a detained person may be a victim of torture. As set out above, there was no examination within 24 hours of admission as required by rule 34(1) of the DCR 2001. In D1527 case, Healthcare only ever issued one Rule 35 report. That report, discussed in the previous questions in this section, only dealt with the issue of whether there were concerns that D1527 was a victim of torture. On that point it accepted he was credible. It omitted the other obviously significant issues about suicidality and mental health. These would have been obvious from reading his medical records alone. The rule 35 report failed to reach a conclusion on whether detention was injurious to D1527 health and expressed no concern

		about D1527 suicidality. It was wrongly treated by the Secretary of State as not requiring release of D1527 in the circumstances. D1527 detention and healthcare records demonstrate that he was consistently self-harming, expressing suicidal ideations and attempting suicide while detained at IRC Brook House. Detention centre healthcare staff should have issued a Rule 35(2) report raise concerns about D1527 suicidality by 24 April 2017 at the very latest, by which point the strength of D1527 suicidal ideation was clear. For similar reasons, by that date healthcare staff should have become aware that detention was having an injurious affect on D1527 mental health. The impact of detention on D1527 and his suicidal intent was regularly recorded by healthcare staff in the build up to these events, particularly in D1527 appointments with Registered Mental Health Nurse Karen Churcher. This includes the following entries: • 12 April 2017: "States he has active thoughts to kill himself. Has a plan to hang via his bed sheets. Kicking over the chair so that he dies. Informed that Oscar 1 would have to be informed about his disclosure. Was not happy as he does not wish to be watched, just wants to die." • 13 April 2017: "He still holds suicidal thoughts but has managed not to act on them." • 21 April 2017: "It was explained that often if there is a risk that he may harm himself they will not release as detention is

		a safer place for him. He then stated he just wants to die…. Oscar 1 informed." These entries all lead up to D1527 repeated suicide attempts over 24-25 April 2017. Karen Churcher felt sufficiently concerned about his intent to inform Oscar 1 and yet failed to arrange a Rule 35(1) or (2) with the doctor. Her advice to D1527 on 21 April 2017 was significantly concerning – as D1527 sets out in his witness statement at paras 41, 65 and 141, this led to him distrusting and not wanting to report the full extent of his symptoms to Healthcare in case it resulted in his detention being prolonged. It also revealed a significant misunderstanding on Karen Churcher's end as to the Home Office's policies on vulnerable detainees and the Rule 35 process if she thought detainees at risk of harm were more likely to stay in detention. A complaint was sent to the Home Office by Duncan Lewis about her comments on 27 April 2017 asking them to *"urgently review the capacity of Healthcare staff at IRC Brook House to manage our client's complex mental health needs. In light of the comments of Nurse Churcher, we no longer consider that IRC Brook House offers care of sufficient quality to ensure that our client can be safely detained."* (HOM000241) There are also significant concerns about Karen Churcher's levels of care, competence and sympathy to D1527 mental health and suicide risk, based on comments captured by Panorama, that are discussed below in response to questions 66-67. D1527 frequently raised the failure to produce Rule 35(1) or (2) through correspondence sent by his solicitors on 31st March 2017 (prior to transfer- see WS para 11); 5 April 2017- WS para 12; 6 April, 13

		April 2017- WS para 12-13, 26 April 2017- see WS para 62; and 27 April 2017- WS para 67. The issue was further raised in the pre-action correspondence on 31 May 2017 and in the pleadings of the judicial review claim filed and served on 7 June 2017 – see WS para 109 and in the skeleton argument dated 12 June 2017 for the interim hearing. No action was taken by the Home Office in response The only action taken at Brook House was to conduct the rule 35 examination and report on 17 April 2017 which should, if properly conducted, have led to D1527 release, but through incompetence of the examination report, and failures by the Secretary of State did not do so. The damning failures at Brook House on Rule 35 can be seen in the FOI data at Annex 12 to the statement of Reverend Nathan Ward. This reveals only a handful of Rule 35(1) reports are issued by healthcare at Brook House each year between 2013 and 2021, and even more concerningly there has never been a Rule 35(2) report issued during the same period. We have not seen the data prior to 2013 but see no reason as to why it would be different. The absence of such reports, and the clear misunderstandings exhibited in D1527 case that the onus is on a detainee to make their case why they should not be detained for medical reasons, indicates a complete operational failure from the Home Office in administering the detention system in accordance with the Detention Centre Rules stipulated by parliament, and by her contractors in managing the system in accordance with their legal obligations.

57.	Did you ask for a report at any other point and if so, was it provided?	Yes, in correspondence dated 31st March 2017 (prior to transfer); 5 April 2017, 6 April 13 April 2017, 26 April 2017 and 27 April 2017, as explained in answer to Question 56.
58.	If you did, did you tell a doctor that you were tortured? Did you feel that you were believed?	The doctor who completed the Rule 35(3) report accepted that D1527 had been tortured and described him as "credible". The problem with the Rule 35 process in D1527 case is that Healthcare consistently failed to investigate and report D1527 suicidality and deteriorating mental health to the Secretary of State for the Home Department.
59.	Was anything done after this?	Not applicable, see answer above.
60.	Have you got any further comments to make about the process?	At the time D1527 was detained, it is to be inferred that there appears to have been a belief amongst Healthcare staff that a Rule 35 report could only be issued in response to a detainee raising concern that they had suffered from torture. Vanishingly few Rule 35(1) (detention injurious to health) and no Rule 35(2) (detainee expressing suicidal intentions) were issued, even for detainees like D1527 who very clearly fulfilled the criteria for a Rule 35(1) and Rule 35(2) report. The failure to apply what is one of the only safeguards against the detention of the vulnerable has been a cause of repeated criticism in the High Court and above since at least 2006.

		Dr Basu's report dated 27 December 2017 confirms that it would have been appropriate to issue a Rule 35(1) and Rule 35(2) report upon D1527 arrival at IRC Brook House (CPS000011).
61.	Overall, based on your understanding of the process and its purpose, provide your opinion onthe Rule 35 process that was carried out in your case.	For the reasons given above, the Rule 34 and 35 process did not operate effectively in D1527 case and meant that where he should have been released he was not. But the failure here was not limited to a failure by the Secretary of State's own processes, there was also a defiant refusal to comply with the law when prompted (repeatedly) to do so by D1527 solicitors. It was only the High Court's intervention which was able to give effect to the proper course in this case, namely that D1527 should not be detained. Without wishing to repeat the history again, it is worth repeating that at the very least the coherent and objective information about D1527 provided by Dr Brandao sent to the Secretary of State on 6 April and by Dr Thomas in her report dated 31 May 2017 and sent to the Secretary of State by D1527 solicitors should have prompted processes leading to release. The Secretary of State was legally required to considerthese reports. The SSHD's own policy indicated that rule 35 reports should be considered within 48 hours. . If that had been done then D1527 would either have been released by the Secretary of State for the Home Department or his solicitor would have been able to apply for judicial review of the decision to detain much earlier and secure his release.

Rule 40 Specific - 24 – 25 April 2017		
62.	Please refer to document SXP000057 p. 7, lines 35-40 and CJS001085 p. 2, which record that on 24 April 2017, you learned that staff on C wing had moved another detainee into your room without first removing your possessions. This increased your depression, and you threwa chair out of anger. On 25 April 2017 you refused to leave the D wing courtyard after attending Sensitive/Irrelevant and were punished for the protest by being on 23 hour lock up (Rule 40) and proceeded to self-harm by first beating your head against a door, then by attempting to self-strangulate and then by attempting to swallow a phone battery. *a.* Is this account correct? *b.* Do you have anything further to add which is not covered above?	Please see D1527 witness statement at paragraphs 62—79 and throughout.
63.	Please refer to document HOM000769, p. 7-8, which sets out Nurse Jo Buss's assessment that you will be able to cope with	There is no record of any assessment having taken place or that Nurse Jo Buss tried to assess D1527 but was unable to do so. The ACDT

	period of removal from association, and that your mental health will not deteriorate. Do you remember being assessed by Nurse Jo Buss before starting Rule 40? Do you have any other comment to make on this?	records makes no reference to Nurse Jo Buss being present around the time that D1527 was placed on Rule 40 (CJS001085). Nurse Buss should have attempted to assess D1527 and in particular asked him to express how he felt about being removed from association before completing document HOM000769. Even if D1527 was unwilling to take part in the assessment, she could have made physical observations based on his presentation and reviewed the ACDT records for the preceding 36 hours, which would have informed her the D1527 was suffering a rapid deterioration in his mental state following the move to E-wing. Moreover, if Nurse Buss was unable to carry out a proper assessment of D1527 mental state then this should have been recorded on the form.
64.	Please consider document HOM000769 at p. 5 which refers to resumption of association asyou said you wanted to go back to A wing. iii. Is this correct? iv. Why did you feel this way? v. How soon after Rule 40 did you mention this? Before or after self-harming by ligature? vi. Pg 10 appears that at 10:30 (which is potentially meant to	It is unclear whether this document refers to 'A-wing' or 'a wing', meaning any other normal wing rather than E-wing. D1527 had previously been on C-wing and it is likely that he wanted to return to C-wing. Throughout his period of detention D1527 expressed a wish to remain in normal association. From the ACDT records it is clear that, despite his severe mental illness D1527 engaged well with other detainees and is often recorded as chatting with another detainee or getting involved in wing activities like playing pool. Even when placed under Rule 40, D1527 maintained contact with other people using his mobile phone. D1527 relationships with other detainees were obviously a protective factor for his mental health. As well as providing D1527 with company

		refer to 22:30) on 25 April (this may be an erroneously reference and the date in question may be 26 April) you were told you would be taken off Rule 40: 1. Was such a discussion had with you on evening of 25 April? 2. If not, was such a discussion had at another time? 3. If yes, do you know of any explanation as to why they wouldn't remove you from Rule 40 until the next morning?	and support, his roommates also raised the alarm when D1527 was self-harming (such as the incident at 00.00 on 24 April 2017). For these reasons it is clear that D1527 request to remain in association and reluctance to be removed from his friends and place on E-wing was an attempt to protect his mental health. This should have been clear to staff at the time. D1527 consistently expressed a desire to avoid being separated from other detainees. The refusal to return to E-wing, which triggered the decision to place him on Rule 40 at 17.00 on 25 April 2017, was because he did not want to return to a single occupancy room on E-wing. The note at pg. 10 of HOM000769 must be incorrect and in fact refer to a conversation which took place on 26 April 2017. At 22.30 on 25 April 2017, D1527 ACDT document records that he was lying in bed under the duvet cover talking to someone on his mobile phone (SXP000125_0009). There does not appear to have been any discussion with D1527 about removing him from Rule 40 until the morning of 26 April 2017.
65.	Please consider document HOM000241 which notes at pgs 4-5 that you told your solicitors you did not get served with written reasons - did you ever get them?		The Rule 40 Notice dated 17.00 25 April 2017 was not disclosed to D1527 or his solicitors while he was detained at IRC Brook House. D1527 should have been served written reasons within 2 hours of being

		placed on Rule 40. D1527 solicitor specifically requested the Rule 40 notice in correspondence on 26 April 2017. See WS para 62.
Specific Incident – 4 May 2017		
66.	Please consider document HOM000251 which states you were put on Rule 40 after jumpingonto D wing netting. It states you refused to comply with instructions, started to get irate, fiddled with your pockets, and refused to empty out your pockets. It notes a significant historyof self-harm and suicide attempts, and a fear you had something to harm yourself/others with,and states that force was used to prevent this and to relocate you to E wing vii. Is this account correct? viii. If not, please set out your account, save as already covered above, of why you were placed on Rule 40. ix. Please note CPS000025 at pg 18 which records that "*officers said he had been told he could not have a new plastic plate*" - is that accurate?	The decision taken to use Rule 40 removal from association against D1527 on 4 May 2017 was unlawfully taken by DCM Steve Dix. The decision was not shown to be necessary in the interests of safety and security of centre and there was no evidence it was of such urgency that DCM Dix could not have sought the views and authority of the Home Office before the decision was taken. The situation had already been de-escalated by allowing D1527 to come off the netting and calm down in a friend's cell. There was no-going risk that would require D1527 to no longer be allowed to associate with other detainees. The decision was purely to punish D1527 It took no regard to the mental health impact or increased suicide risk any such decision would have on D1527 The decision only sought to escalate tensions building up to (unlawful) use of force by officers against D1527 to move him to E-wing. The unlawful of this decision is now set out in detail. **Paperwork** Rule 40 authorised by DCM Steve Dix at 17:45 on 4 May 2017 for initial 24 hours as a 'case of urgency: *"**Detainee D1527 has been relocated to Care and Separation Unit on rule 40 after jumping on Delta Wing netting. Mr D1527 removed himself after approximately 30 minutes, he went to a***

		friends room to calm down. *I spoke to Mr D1527 about his behaviour and the consequences of his actions, he refused to comply with the instructions given. Mr D1527 was already on an ACDT and has a previous significant history of self harm and suicide attempts, he started to get irate and started to fiddle with his pockets and refused to empty out his pockets or remove his hands. Fearing he potentially had something he could harm himself with or others force was used to prevent this and relocate him to Eden Wing. He was placed into E008 and watched constant for a couple of hours after the use of force. A full search was also conducted and nothing was found. Duty Director, Home Office, IMB and Healthcare are aware."* – **In bold are the reasons for Rule 40 removal from association. Everything else describes what happens after DCM Dix goes to enforce the decision to apply Rule 40. The rest is therefore irrelevant in respect of whether there was lawful or proportionate justification decision.** An IS91 RA Part C was issued to Home Office by Steve Dix stating the same as above Copies of documentation said to be given to Secretary of State, Contractor, Visiting Committee, Medical Practitioner, Religious Affairs Minister and Detainee at 21:00 on 4/5/17. Observations: • *4/5/17 – 17:40 – Arrived on Eden wing E/008 on Rule 40. Full search carried out and new clothing issued – DCO G. Croucher*

		• *4/5/17 – 17:50 – Offered dinner but refused – DCO G. Croucher* • *4/5/17 - 19:50 – sleeping under his cover. Movement – DCO G. Croucher* • *4/5/17 – 21:00 D1527 is having a shower – DCO G. Croucher (At the time it is claimed he was issued with his Rule 40 paperwork. No entry to confirm paperwork given to* D1527 • *4/5/17 – 21:50 – Laying in bed on constant supervision – [officer name unclear]* • *4/5/17 -22:15 – DCM night observation, D1527 has just had ACDT case review conducted, taken off constant supervision and placed onto hourly observations, no thoughts of self-harm, said he was sorry for jumping on the netting, and understands why he is on rule 40 – "Lynch?"* • *5/5/17 – 8:15 – Refused breakfast – Charlie Francis* • *5/5/17 – 10:25 – D1527 calm, compliant, did not explain why he got on netting. To move to Eden Wing – HO Steve Levett* • *5/5/17 –10:25 - D1527 was [?] compliant, he stated a number of things contributed to him getting on the netting. He said things are ok now and he was advised of what would have happened had he stayed on the net. Moved to Eden – Duty Director Houghton* D1527 was removed from Rule 40 at 10:50am on 5 May 2017 by DCM Dave Roffey: *"Mr D1527 has been removed from Rule 40 and placed on Eden wing."*

		Background is provided by DCM Dix in the DCF2 Use of Force report that is not recorded in the Rule 40 decision: *"...I Detention Custody Manager {DCM} S Dix was working at Brook House IRC on Thursday 04/05/2017 at roughly 16:30 when I attended a first response call to D wing. Upon arrival I saw detainee D1527 on the first floor netting who was shouting in his own language and very irate. Mr D1527 refused to engage with any staff members really and other detainees tried to engage with him to which he did.* ***After a short while he agreed to come off the netting but only if there was no staff around, I agreed to this as detainee D378 and D812 were talking to him once D1527 was off the netting he went into there room to calm down****. I have gone to speak D378 and D812 after this incident for a post care de-brief and they are both happy with what they witnessed and understand the necessary actions taken.* *A* ***short while later I went back to that room to speak to D1527 about his actions he was frustrated with staff members*** *but I tried to explain the they could not leave him alone was because of the way he was behaving.* ***I explained due to his behaviour he would need to comply and go to the CSU on rule 40*** *he said "No""* **DCR Rule 40** 40.—(1) 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. (2) **In cases of urgency, the manager of a contracted-out detention centre may assume the responsibility of the Secretary of State** under paragraph (1) but shall notify the Secretary of State as soon as possible after making the necessary arrangements. (3) A detained person shall not be removed under this rule for a period of more than 24 hours without the authority of the Secretary of State. (5) Notice of removal from association under this rule shall be given without delay to a member of the visiting committee, the medical practitioner and the manager of religious affairs. (6) **Where a detained person has been removed from association he shall be given written reasons for such removal within 2 hours of that removal**. (9) **The manager, the medical practitioner and (at a contracted-out detention centre) an officer of the Secretary of State shall visit all detained persons who have been removed from association at least once each day for so long as they remain so removed**. **G4S Policy, Removal from Association dated 22/8/16** **G4S' policy on removal from association at the time is concerning in appearing to suggest that Rule 40 can be used as punishment – page 5:** "They are not given the freedom of movement that Detainees

		in normal accommodation are given. This **acts as an incentive to conform to the Detention Centre rules** and therefore be placed back on to normal accommodation. The **primary function of the CSU unit is to cater for those detainees who are proving to be too difficult to manage in the more relaxed regime of ordinary accommodation**" Page 6 – "Where possible, prior authority regarding the use of CSU Rule 40 should be obtained from a Home Office Manager, however, in the event that CSU — Rule 40 is used retrospectively, it is the responsibility of the Detainee Custody Manager to notify the IMB, Home Office Manager, Healthcare and the Religious Affairs Manager that a Detainee has been removed from association, and that action has been recorded. Detainees will received written confirmation of the justification of their Removal From Association within two hours of placement into CSU" Page 20: "Detainees located in the CSU Unit (Rule 40) will be assessed by Healthcare within two hours of placement. The healthcare member of staff will confirm the Detainees suitability to be placed into Care and Separation. Based on the Healthcare Assessment, the Duty Manager/Duty Director will then make an informed decision about the individual's ongoing regime and location" No guidance on how to make a decision under R40 and extent that mental health may be relevant

		For this Rule 40 decision to be lawful, DCM Dix is required to show the following for which he has completely failed to do: • That the decision was **necessary** and **in the interests of security or safety**: o He has not explained why it is necessary in the interests of safety or security. o He has not explained how any lesser interference with D1527 rights could not have solved the situation. o He has not even said it was in the interests of safety or security – the only explanation is what happened (he jumped on the netting) – in the absence of any linking to safety/security, one can only read that it was a 'punishment' for jumping on the netting. o The use of force report supports the suggestion that the Rule 40 was for 'punishment' – "*I explained due to his behaviour he would need to comply and go to the CSU on rule 40"* – this is not about his security or safety risk. DCO Yates' use of force report supports claim it was segregation for punishment, not DCM Dix's comments to D1527 *"Myself and DCM Steve Dix agreed to enter the room and speak to Mr D1527 and ask him to walk with us to Eden wing as his behaviour was not acceptable*." (CJS005530_0018) o No alternative measures were considered. In fact it appears that DCM Dix had in fact already de-escalated the situation and removed any security or safety risk in D1527 remaining on the netting. He successfully

		negotiated for D1527 to come off the netting by removing staff from the scene and allowing detainees D378 and D812 to move him safely to their room. By DCM Dix's own version of events D1527 had calmed down. Instead DCM Dix took the decision to use Rule 40 – his decision and the necessity must be taken in these circumstances. DCM Dix's decision to segregate only served to escalate the situation, resulting in use of force – whether the use of force was lawful or unlawful (we say clearly unlawful), the decision to move D1527 to Rule 40 only served to increase the risk of safety and security to both D1527 and staff in that use of force ○ **No consideration given to D1527 mental state and how his actions may on the netting related to acute mental distress:** ▪ D1527 was on a fifth day of food refusal and the events were related to D1527 wanting to re-start eating (HOM000519) ▪ Brook House shift handover for morning of 4/5/17 (CJS001259) – D1527 listed as being on day 4 food and fluid refusal and an on open ACDT. Records of these vulnerabilities were known and available to DCM Dix ▪ D1527 was diagnosed with PSTD on 2 May 2017 by IRC psychiatrist Dr Belda. Mental health nurse Karen Churcher was present when Dr Belda diagnosed D1527 with PTSD – she

		completely the healthcare entry. Karen Churcher was said to be present throughout D1527 planned transfer to Rule 40 after netting incident – she can be seen in the Panorama key footage and in CCTV. D1527 mental health, his recent PTSD diagnosis, his protracted self-harm/suicide risk, his fact of being on ACDT and his food refusal state should all have been known to DCM Dix when he made his decisions to RFA and use force ▪ DCM Dix was plainly aware of D1527 self-harm/suicide history and risk – his use of force report seeks to justify his force on the basis that he *"felt fearful for his safety as he has a history of self harm…"* (CJS005530_0008) ▪ **The evidence strongly suggests DCM Dix was taking decisions in relation to D1527 at a time where he was clearly unsympathetic or uncaring of the consequences to D1527 mental health or suicide/self-harm risk. This can be seen in DCM Dix's response to Callum Tulley when asked about the risk of D1527 jumping off the suicide netting: "Oh well, its his own choice innit"** (KENCOV1012 – V201705040022 clip 2) ○ **No consideration given to impact on D1527 mental health in being removed from association**:

		▪ 'No 'Removal from Association Initial Health Assessment' is completed by Karen Churcher – no form is attached to the Rule 40 decision (CJS001026) as per G4S RFA policy at para 20 (CJS000725) ▪ Karen Churcher only completes an F213 report to record D1527 injuries from the use of force to move him to E-wing to be segregated ▪ DCM Dix and Karen Churcher should both been aware of his vulnerabilities, his self-harm/suicide risk, his PTSD diagnosis and possible effects on his mental health – yet the decision is still taken ▪ D1527 is placed on constant supervision on arrival to E-wing given the clear self-harm/suicide risk ▪ There is evidence that Karen Churcher was unsympathetic to D1527 and minimising her concerns about his mental health. She is seen laughing along with other colleagues about the fact D1527 was on netting due to a 'dirty plate' – "If he didn't have to do the washing up, he didn't have to go that far did he… I don't know (laughing) it's a dirty plate" – this is despite knowing D1527 was food refusing, on ACDT and suffering from PTSD – **serious questions about standard of care D1527 receiving**

		▪ There are concerns to the extent to which healthcare would challenge or undermine a decision by G4S officers to segregate, particularly with healthcare also being G4S employees – they do not create an independent oversight on the health risks on decisions to segregate. In this specific context, the compromise of this independence (and the chances of healthcare challenging a segregation decision) can be further emphasised by the fact that Steve Dix and Karen Churcher are 'Facebook' friends. Steve Dix's wife, Jacintha Dix, was healthcare practice manager at Gatwick IRCs between January 2011 and September 2021, thus effectively one of Karen Churcher's superiors. ○ **The risks of segregation to D1527 are recorded by Dr Thomas in her medico-legal report. It was not available to the decision-makers at the time of the decision (Dr Thomas assessed D1527 on 20 May 2017) but show the impact of these decisions on D1527** ▪ Dr Thomas: • Para 160: "As noted above, **D1527** is frequently taken to the IRC's psychiatric wing, 'E Wing', when he is acutely and recurrently suicidal and there kept under 24 hour per day

		observation. **D1527** said that he hates going to E Wing and that it makes him feel *'much worse'* in mood and more suicidal when he goes there due to the constant scrutiny, solitary confinement with the exception of the observing officer(s) and lack of any privacy." (HOM002997_0056) • Para 162: "It is my view that **D1527** removals to E-Wing are at best ineffectual therefore and, at worst, are contributing significantly to a very stuck and vicious cycle of self-harming behaviour, solitary containment, worsening mood and increased escalation of self-harming behaviour and intent to die." (HOM002997_0057) • That what is being done by the decision under Rule 40 is so that he **should not associate with other detained persons** o Rule 40 is about removing an individual from association *from other detained persons*. Safety/security concerns that require 'removal from association' must be seen in that light. It is taking a decision that a detainee cannot associate with others o If any security risk still existed (which DCM Dix did not set out and which appeared a remote risk anyway) it was presumably a concern that D1527 would jump

		back on the netting. This risk is in no way to do with taking him away from *other detainees* ○ In fact it appeared that D1527 frustration was with staff, not other detainees – he was in no way a security or safety risk to other detainees – DCM Dix confirms in the UoF report that D1527 was "frustrated with staff members" and would only come off netting if staff left • That it was a **case of urgency** meaning that the authority of the secretary of state could not be sought – i.e. the on-site Home Office team ○ The Rule 40 decision cannot pass this test ○ Even if a possible risk of safety or security could have existed, it was not an urgent or immediate risk that required bypassing the authority of the Secretary of State on the basis of urgency. ○ DCM Dix confirmed that D1527 went to his friends' cell to calm down – he had successfully de-escalated the situation. There was no urgent concerns that required his immediate removal from association ○ D1527 jumping on the netting appeared to be seen as a major event in the centre with several staff members present. It is inconceivable that on-site Home Officials were not present or at least being informed in real time of the incident. The decision should have been taken by the Home Office • D1527 was not given written reasons for his removal from association within 2 hours

		○ The decision was made at 5.25pm. D1527 arrived in R40 at 5:40pm. ○ DCM Dix states he served the paperwork on D1527 at 9pm ○ The constant observations confirm D1527 was in the shower at 9pm. At no point in the observations does it record that D1527 was given the paperwork ○ Even on DCM Dix's account D1527 was not provided with written reasons for his removal from association within 2 hours. ○ The evidence suggests he was likely given it later than this. Our firm were faxed a copy from Brook House at 8.13pm on 5 May 2017, the day after and when D1527 had been taken off RFA.
67.	Please consider document HOM003017, in which Julie Galvin (PSU) requests the removal from association initial health assessment for this Rule 40 period. According to p. 34 of Ms Galvin's report (CJS001107) it was undertaken and no issues were identified. d. Do you remember being assessed by healthcare before beginning Rule 40? e. Were you served with a notification of this report (as per document HOM003017 p. 34 [7.122])?	The discrepancy between HOM003017 and CJS001107 is highly concerning. The email from Karen Goulder at G4S on 22 February 2018 suggests that the initial health assessment was not on their records. This is consistent with the fact there is no such health assessment within G4S' disclosure to the Inquiry and there is not an assessment attached to the Rule 40 paperwork on this decision (CJS001026). There is no explanation as to why Karen Churcher did not complete the initial health assessment form – CCTV shows she was present throughout D1527 transfer from D-wing to C-wing. Her failure to do so is consistent with our concerns that she showed a lack of care, sympathy and attention to D1527 case – see her comments from Panorama that we have summarised at question 66 above where she laughs at D1527 apparent over-reaction in jumping on the netting.

		If Karen Churcher had completed the health assessment, she would have had to record that D1527 was on ACDT, that he had been diagnosed with PTSD two days earlier and that he had repeatedly told her he had suicidal intentions. But she failed to complete this assessment. It is significantly concerning that Julie Galvin would record that an initial health assessment was completed when Karen Goulder confirmed there was not one on file. She also claimed that D1527 was served with his notification of Rule 40 on 4 May 2017 despite again Karen Goulder confirming they did not have this on record. We believe this is consistent with our concerns that the PSU investigation lacked independence or sufficient scrutiny – see our responses at question 112 below. D1527 was not served with a notification of the Rule 40 decision within 2 hours as required – see question 66 above.
68.	Save for the incidents set out above, were you ever placed on Rule 40?	D1527 is unsure. The official records speak for themselves, though of course they cannot be presumed to be accurate. At WS para 29 and 89 he says he was held on E wing on "multiple" occasions: some of those would have been rule 40- or an unlawful variant of it. At paragraph 47 he says that he knows that force was used against him "often" to bring him to E wing. WS para 123 he says he was on rule 40 on "several" occasions.
69.	If so, when and why? Was it connected to any self-harming incident? How long were you placed on it?	n/a

70.	Have you got any further comments to make about the process?	See full and detailed response on the problems with the Rule 40 decision at question 66 above D1527 sets out in his statement at length how terrified he was of E Wing- which in his case was often part and parcel of being on rule 40. He has set out his nightmarish experiences there and of the consequences for his increased self-harm and suicidality. The statement also sets out the failures to provide reasons for putting him into isolation, even when requested by solicitors. The statement also makes clear the inappropriateness of the use, and that it appears to have been used after staff carried out assaults. The implications for D1527 of being assaulted and then subjected to an experience that staff knew he could barely cope with, while being denied reasons or access to a lawyer would have been obvious to D1527 particularly given the experiences he had had before coming to the UK and in being detained in Belmarsh.
71.	Do you have anything you wish to add in terms of the Rule 40 process? What were your views on being placed on Rule 40?	D1527 hated being on Rule 40 and found it very frightening and traumatic. D1527 addresses rule 40 at paragraphs 123-127 of his statement. In his case, he was usually taken to E wing when on rule 40 (though sometimes he was also taken there when he was not on rule 40). As to E Wing- which was frequently part and parcel of the rule 40 process- see D1527 witness statement at paragraphs 47, 61, 75, 79, 89-102 of his witness statement
72.	How did being held under Rule 40 affect you (if at all)?	See D1527 witness statement as detailed above.

ACDT		
73.	Please consider documents CJS001073, CJS001035, and SXP000125. These documents refer to an ACDT log opened on 20 March 2017 at HMP Belmarsh. They suggest that you continued to be monitored when you arrived at Brook House on 04 April 2017 and that the ACDT was closed on 27 May 2017 (HOM032226 pg. 20). x. Are there any general comments that you would like to make about the process?	Although an ACDT document was open when D1527 arrived at IRC Brook House, no Rule 34 initial health assessment was carried out and none of the Healthcare staff involved in D1527 case initiated the process of producing a Rule 35(1) (detention injurious to health) or Rule 35(2) (detainee expressing suicidal intentions) report. The fact that D1527 arrived from HMP Belmarsh with an open ACDT document should have led IRC Brook House to at least consider issuing a Rule 35(1) or Rule 35(2) report. As noted above, no Rule 35(1) or Rule 35(2) report was issued during D1527 detention, despite D1527 repeatedly engaging in self-harm and making numerous suicide attempts.
74.	Please consider document CJS001076 xi. Have you seen this document before? xii. Did anyone discuss with you your triggers/warning signs? xiii. Did anyone ask you to agree to share your information to relevant staff?	D1527 cannot remember details from this conversation which occurred over 4 years ago. The absence of any record of D1527 trigger/warning signs or his consent for information to be shared with the Home Office strongly indicates that neither issue was discussed with him.

75.	Please consider document CJS001049. At pg 3 in respect of a case review on 7 April 2017it is said you were struggling with anxiety attacks, Nurse Karen Churcher told you that you have an RMN appointment on 12 April 2017 and they can assist with coping mechanisms. At CJS005997 pg 32 on 12 April 2017 at 15:26: it is recorded that you went for a mental health appointment but it clashed with doctor's appointment; and that at 18:02 you saw RMNbut that there was no discussion about anxiety a) Were you asked about anxiety attacks? b) Were you introduced to coping mechanisms for anxiety attacks (then or at all)?	From the records it appears that the only coping mechanism explained by Nurse Karen Churcher was the use of elastic bands to prevent more serious self-harm. The notes for the appointment on 12 April 2017 do records that during the session D1527 "*Worked on positive forward thinking*.". There is no information about what the involved or how long was spent on that task.
76.	Please consider documents CJS001146 (page 7) entry at 00:15 and CJS001049 entry at 01:15 for 8 April 2017 which state you were banging on the window with both hands and appeared to be holding a card, and later that there were superficial cuts noted to your arm. xiv. Do you recall these events? Please comment if so.	D1527 cannot be expected to remember this event. This incident of self-harm was relatively minor compared to others during D1527 period of detention and there is no reason for him to have specifically remembered this incident.

77.	Please consider documents CJS001049 pg 4 and CJS001146 pg 10, which note a case review on 8 April 2017 in which it is recorded that you said you were not willing to attend any review at any time with anyone xv. Is this account correct? xvi. If so , why did you refuse to engage with the case review?	D1527 attended a large number of ACDT reviews during his time at IRC Brook House. He was unwilling to attend the review on 8 April 2017 but did attend reviews on 7 April 2017 and 9 April 2017.
78.	Please consider documents CJS001146 (pgs 12-13), CJS000611 (pg 1), HOM000547 (pgs2-4) and CJS001049 (pg 7) which record an event on 9 April 2017 when you were recordedto have kicked and thrown a chair and then returned to your room, soon after presenting at Heathcare with a superficial cut to the left wrist. xvii. Do you recall these events? Please comment on what happened if so.	D1527 cannot remember these events. There is confusion within the documents about why D1527 threw the chair. The ACDT documents state that D1527 threw the chair because he was frustrated about a delay in providing his medication or because he was told that he had to collect medication from Healthcare rather than from staff on the wing. However, CJS000611 states that the reason for D1527 behaviour was that the: "*Home Office had advised him that they were trying to obtain a travel document*.". The document makes no reference to the ACDT review which preceded the incident. In light of the differences between different official versions of what happened and the length of time that has elapsed it is difficult to be certain about what caused D1527 behaviour and whether the description of this conduct is accurate.

79.	Please consider document CJS001049 at pg 14 in respect of an entry regarding 12 April 2017 when you saw a RMN and reported suicidal thoughts. Please comment on your recollection of this event.	CJS001049_0014 is an ACDT review from 19 April 2017 and does not contain any discussion about events on 12 April 2017. The mental health appointment on 12 April 2017 has already been addressed in response to Question 75. That entry records a clear expression of suicidal *intent* by D1527 about how he was going to kill himself. It was sufficiently concerning for Karen Churcher to inform Oscar 1. The entry suggests she failed to speak with a doctor to ensure a Rule 35(2) report was completed.
80.	Please consider document CJS001124 which at pg 14 has a case review entry for 18 April 2017 at 11:30. What if anything do you recall about your condition at this time?	D1527 had self-harmed at 22.11 on the previous day (recorded in CJS001124 at pg. 13). D1527 was clearly very mentally unwell at the time of the case review on 18 April 2017.
81.	Please consider document CJS001049 at pg 14 in respect of a case review on 19 April 2017, in which it is said that you refused to engage with anyone or do a case review xviii. Is this account correct? xix. If so , why did you refuse to engage with the case review?	It is unclear why D1527 did not engage with the ACDT review on 19 April 2017. D1527 did take part in ACDT reviews on 18 April 2017 and on 21 April 2017. D1527 was severely unwell at the time and it is understandable that he may not have always felt well enough to engage in the review process.
82.	Please consider document CJS001049 at pg 15 in respect of a case review on 21 April 2017at 10:00, where it is said you were forgetting to take medication consistently and also reported	There was a long initial delay in providing D1527 with his medication when he arrived at IRC Brook House from HMP Belmarsh. It appears that once at IRC Brook House D1527 was expected to take responsibility

	thoughts of self-harm. xx. Is this account correct? xxi. If so, did staff do anything to help you with this? xxii. If so, do you feel it assisted?	for obtaining his medication from Healthcare (see documents discussed in Question 78 and response). The same issue arose on 18 April 2017 and the only support D1527 was offered was a suggestion that he use an alarm on his phone to remind him to go to Healthcare and collect his medication. D1527 medical records (document CJS005997) do not confirm whether he was generally able to remember to obtain medication or not.
83.	Please consider CJS001049 at pg 16 in respect of a case review on 21 April 2017 at 17:20 in which it is recorded that you said you wanted to be left alone a. Is this account correct? b. If yes, why did you feel that way?	D1527 often expressed a desire to be left alone while at IRC Brook House. During his time at Brook house, D1527 was subjected to repeated and prolonged use of constant supervision to manage his acute suicide and self-harm risk. The prison policy on ACCT (for which ACDT is based on) - PSI 64/2011 (which has application to prisons and to NOMS operated IRCs) - recognises that "The process of being constantly supervised by a member of staff can be de-humanising which may increase risk. … [It] is intended to be in place for the shortest time possible…". In this context, it is unsurprising he often felt a need for privacy. There is case-law which confirms that the overuse of constant supervision in an IRC can breach Article 8 ECHR - *IS (Bangladesh) v SSHD* [2019] EWHC 2700 (para 184)
84.	Please consider document CJS001030 which records on page 8 a review at 22:30 on 23 April 2017, where you were recorded to be repeatedly banging your head against the cell door.	D1527 self-harmed consistently while at IRC Brook House and cannot remember each incident. He reported banging his head to Dr Thomas at paragraph 74 of her report refers to a "visible dent" in his forehead (quoted at para 85 of the WS. See also paragraph 35 of his statement of 19 January 2018 quoted at paragraph 49 of his WS. From the

	a. Do you recall this incident? If so, please comment on it and what if anything was done.	records provided by G4S it appears that no action was taken to prevent D1527 from self-harming and no self-harm incident was reported.
85.	Please consider document CJS001035 which contains a case review on 25 April 2017 at 10:45 hours in which it is recorded that you say you harmed yourself due to being put on E-wing. xxiii. Save as set out above, do you have any further comments on these documents or on this incident?	The self-harm incidents are discussed above. In this ACDT review D1527 was expressing his desire to return to a normal wing where he could associate with other detainees freely rather than being in a single occupancy room on E-wing.
86.	Please consider document CJS001085 at pg 17 in respect of 25 April 2017 which records at*19:01 Kicking and banging door 19:01; tied a t shirt around his neck; angry and upset; had [?] phone battery in his mouth; attempted to self-strangulate in toilet 19:40; tried to climb thewall 20:20, said sorry 21:10.* xxiv. Save as set out above, do you have any further comments on these documents or on this incident? xxv. Do you recall climbing the wall? xxvi. Did you apologise? If so, what for?	

87.	Please consider documents CJS001002 pg 39; CJS001035; and HOM000769 pg 5. In a case review on 26 April you were recorded as having said that you would kill yourself and would rather die than return to Egypt. xxvii. Do you recall this, and if so, are these records accurate? xxviii. Do you wish to add anything else?	CJS001002 is not a valid document reference number. D1527 has discussed his feelings in detention in his witness statement.
88.	Please consider document CJS001035, in relation to a case review on 28 April at which yousaid that if you were asked anything you would "*always say I am fine because nothing matters*". What did this mean?	Understandably, at this point D1527 lost confidence in the ACDT review process. On 25 April 2017 D1527 has expressed his desire to return to a normal wing but instead been placed on Rule 40. His frustration is evident in the ACDT review on 28 April 2017.
89.	Please consider document CPS000025 at pg 22 in respect of an incident on 14 May 2017, in which DCM Ramone is recorded to have made a comment that you had only been in detention one month so it can't be that bad, to which Dan Small then laughed xxix. Can you recall hearing such comments?	D1527 cannot reasonably be expected to remember every disparaging and derogatory comment made by staff during his time at IRC Brook House. The remarks reported by Callum Tulley are consistent with the secret recordings he made of staff making similar comments in front of detainees.

90.	Save for the incidents considered above, do you have any further comments on ACDT plans or reviews?	ACDT reviews in D1527 case were carried out frequently but D1527 views were generally ignored by staff. D1527 found being subject to constant or frequent observation difficult. While at times it may have been necessary because of D1527 mental health crisis, there was a failure to utilise the records to make informed decisions regarding D1527 The most significant omission was the failure to issue a Rule 35(1) and Rule 35(2) report, but staff also failed to notice the precipitous decline in D1527 mental well-being from 23 April 2017 to 26 April 2017 and take appropriate action. One of the justifications of causing D1527 distress by subjecting him to constant observations is that those observations could be used to enhance his care. The records kept omitted important events, most notably the incident on 25 April 2017 when Yan Paschali choked D1527 In light of this it is impossible to be confident that the records do not omit other examples of mistreatment or substandard care provided to D1527 while he was at IRC Brook House.
91.	Have you got any further comments to make about the process?	See response to Question 90.
Food Refusals		

92.	Documents suggest that you were on food/fluid refusal on 19 April 2017, 22 April 2017 – 27 April 2017, 1 May 2017 – 9 May 2017, 11 May 2017 – 27 May 2017 a. This is for most of the time that you were at Brook House - does that seem accurate? b. Reasons sometimes included the fact that you bought food from the shop. Do you agree that this was sometimes the reason for being recorded as on food/fluid refusal? c. Why did you buy food from shop rather than eat at the servery? d. Other reasons often include stress/not hungry - how much did this play a part in your food refusals? e. Case reviews on 17 and 21 May [CJS001035] pgs 15 and 16 suggest you did not like the food and it upset your stomach - how much did this play a part in your food refusals? f. Forms show that you declined to be examined by healthcare i. Is this accurate? ii. Were you offered examination? iii. If yes, why did you refuse to be examined?	D1527 unfortunately is not in a position to remember the dates of each incident of food and fluid refusal and the times in which he may have eaten from the shop. His IRC medical records indicate when his food refusal was *recorded* (which does not necessarily mean he was not food refusing on other dates) and match up with the dates identified by the Inquiry in the question save he also was recorded as being on food refusal on 30 April 2017 too (James Newlands records this as day 1 of a fresh period). IRC healthcare records stop recording D1527 as food refusing from 27 May 2017 and there are no further recorded entries. It is also of note that this in fact coincides with when Sensitive/Irrelevant began. It is unclear what G4S' approach to food/fluid monitoring was during Sensitive/Irrelevant and whether they would note Sensitive/Irrelevant detainees who were observing fasting but would otherwise still have been refusing food. What is clear overall from the records is that D1527 had prolonged periods in which he did not eat and these were primarily linked to his mental distress at being in detention at Brook House. It is also clear that this was well known to staff, to management and to the Secretary of State for the Home Department since it was, among other things, referred to in the medical evidence of Dr Thomas, and the medical records and drawn to their attention in correspondence from D1527 solicitors and through the judicial review claim. The evidence suggests that staff did not fully appreciate the link between mental health and food refusal both generally and specifically in D1527 case.

		In general, there is evidence from the Panorama documentary and the wider transcripts that staff did not take food refusals seriously: • DCM Nathan Ring on Panorama documentary when told by Callum Tulley that a detainee is on food refusal: " *Oh fuck him, cross him off [of the food refuser list]. He's a prick… No I ain't worried about that… Yeah. Penis*" (40:49mins)" • Further elaboration of what Nathan Ring said in transcripts: "*Spat his dummy out [inaudible] he said 'what's happening what happening' told him to 'wait' and he just said 'well I'm not going to eat if you won't tell me what's happening'. 'okay see you later'. Penis… I just chucked another bowl [soup] at him. What a needy fucker he is*." (TRN0000079 – KENCOV1027 – V2017053100007CLIP2) • DCM Chris Donnelly to Callum Tulley and Darren Thomsett: "*I get a bit unprofessional with people saying 'I'm not going to eat'. I'll show you. You know the people that don't eat"* (TRN0000032 - KENCOV1039 – V2017070300018) • Callum Tulley video diary explaining Chris Donnelly's comments further: "*I was asking Chris Donnelly why he thought detainees refused food and he said it's as if they all have soft mothers and that they think somehow, by refusing*

		food that we're going to care about that and that it might help their case. He then imitated baby feeding – its mothers and he' was going "here goes the aeroplane", and basically doing this motion as if it was going into a baby's mouth… Talking about food refusal as if it's an inconvenience to him as a manager and that it's some sort of game. Some detainees might play games, but most of them have serious, serious issues and hunger strike and food refusal is a serious thing. And he just knocks it off as if they're playing games and it's attention seeking" D1527 food refusals set the backdrop to the events of 4 May 2017. As set out in his witness statement at 69-70, D1527 wanted a plate from the welfare office so that he could eat having endured a prolonged period of food refusal. His IRC healthcare records recorded him prior to this as having not eaten on 19 April 2017, 22 April 2017 – 27 April 2017, 30 April 2017 up until events on 4 May 2017. It would have been hoped that staff would have been keen to ensure he started re-eating and encouraged this. However as D1527 sets out in his statement, *"The female officer in the welfare office had said that she had seen both of us in the queue taking food earlier, and so she was not going to give us anything. I was not asking for any food, I was just asking for a plate. I said that this was not right, we have not eaten anything for a long time, we were not in the queue earlier. I told her that I had not eaten anything from them for 30 days. She said that she had seen us,*

		and that she would not give me a plate… She was very aggressive and confrontational. It made me very angry. I went back to my room and I said I don't want to eat anything. Whatever I had from the shop I put I the bin. An officer asked me what had happened and so I told them. One officer eventually brought me a plastic plate. At this point, I was so angry that I broke the plate and put it in the bin. I told the officers to leave me alone, and I closed the door to my room" The failure of staff to assist D1527 with this simple request to help him start eating again ultimately led to significant distress for D1527 who was acutely mentally unwell and on a 5th consecutive day of refusing food. D1527 jumped on the netting in his frustration and distress and in turn he was subjected to unlawful segregation and unlawful force to take him to E-wing. He is recorded as going on to continue food refusal until 9 May 2017. As set out above, D1527 has in his witness statement has been able to identify the officer in the welfare office that refused him the plate as DCO Precious Okolie Nwokeji from reviewing the Panorama footage. Her complete lack of sympathy and understanding of **D1527** situation are reflected in the derogatory comments she makes about him in the Panorama footage: • Precious Okolie Nwokeji: [inaudible] **a bitch because he was told about a plate (**KENCOV1012 – V201705040021 We understand therefore that DCO Nwokeji – as evidenced on the Panorama footage telling Callum Tulley - that she was the source of officers being informed that D1527 was on the netting for 'over-reacting'

		to being refused a plate, as opposed to this being an acute mental health crisis of a deeply unwell individual who was been on food refusal for days. Other staff members in turn joined in laughing at D1527 expense including Karen Churcher: **If he didn't have to do the washing up, he didn't have to go that far did he… I don't know (laughing) it's a dirty plate** (KENCOV1012 – V201705040022 clip 2)
93.	Please consider document HOM032218 which records that immigration enforcement served a Food and Fluid Refusal interventions letter on you on 22 May 2017, and states that you walked out of the room saying that if you do not feel like eating, you will not eat, and you want to die. a. Is this what happened? b. Did the immigration enforcement officer explain to you what the meaning of the letter was?	D1527 is not in a position to remember this event.
94.	Please consider document IMB000036 which is an IMB member visit log for week commencing 22 May 2017, which makes a number of comments about your food refusal situation and the possibility of a life directive	D1527 cannot comment on the views of the IMB, they would certainly not be views that the IMB would have shared with him. It is not entirely clear what is meant by "*The HO is intending to ask him if he wants to sign a life directive ie if he refuses, which is likely, then treatment can be given if it becomes necessary*." As we understand the

	xxx. Is the information given here correct? xxxi. Do you have anything further to add?	IMB suggest the Home Office were considering getting D1527 to sign an agreement that they give him life-saving treatment if his situation deteriorates. If true this is highly concerning and there are significant questions to be asked of the Home Office as to why they believed he was suitable to continue to be detained if such a measure was being considered. The IMB go on to note that D1527 was "One to keep our eye on too". While that was very late, and perhaps already too late since D1527 had already been subjected to multiple assaults, unlawful uses of segregation, and had gone through a prolonged period of suicide attempts, self-harming and food refusals, it is apparent that no eye was kept on him even thereafter. D1527 had already experienced major and lasting harm to his mental health. The IMB as an oversight mechanism had already entirely failed D1527 and continued to do so despite, for example, the report of Dr Thomas that followed shortly afterwards.
95.	Please consider IMB000023 which is an IMB member visit log for the week commencing 29 May 2017, which states that "Jackie" had asked Lui Hiu (report writer) on C wing to speak to you, and that you were under an ACDT about a "food problem". It records that Lui tried to visit you on 4 June but you were not in your room and the wing officers told Lui that you wereok. Lui states that the report says that the ACDT is now closed. xxxii. Is this accurate?	D1527 cannot comment on discussions between the IMB and officers about D1527 whereabouts on this given day or the officers' views that he was "ok".

	xxxiii. Do you recall being spoken to by anyone from the IMB on this occasion or others about food and fluid refusal?	
96.	Save as set out above, did you on any other occasions refuse to eat or drink?	D1527 cannot remember all dates he refused food or fluids. See above, his statements, and medical reports for further information as to the detail.
97.	If you did refuse food or drink on other occasions, how long was this for? What were the reasons? How were you treated?	D1527 cannot remember all dates he refused food or fluids or for how long. See above, his statements, and medical reports for further information as to the detail.
Drugs		
98.	Did you use drugs and/or alcohol, including NPS/'legal highs' (Spice etc) during your detention, or witness others doing so?	D1527 instructs he was not taking drugs and we have seen no evidence in the disclosure that suggests otherwise
99.	If so, a. What type of drugs (e.g. Spice), and/or alcohol? b. When? c. Where did you/others get them from?	n/a

	d. How easy or difficult was it to source drugs or alcohol? e. Did you report drug use to any G4S staff, or anyone else? If so, please provide details including the response? f. Did you or anyone that you saw have an overdose or a bad reaction to drink or drugs? If so, please provide details including how it was it dealt with? g. What, if any, rehabilitative support was given to you/other users of drugs? Was this support adequate in your view?	
Protests		
100.	There was a protest on D-wing on 14 April 2017. Do you remember this? a. Did you take part or witness this? b. What was the protest about? c. How was it dealt with by Brook House staff? d. Was it appropriate in your view, to use force? e. Were any of the underlying issues that caused the protest addressed?	The records suggest D1527 was located on B-wing on 14 April 2017 (HOM003036_0040).

101.	Did you observe or take part in any other protests at Brook House during the relevant period, save as already considered above?	n/a
Clinical Care Issues		
102.	Save as already set out above, did you suffer from any physical or mental health issues when you were a detained at Brook House? If so, please provide a brief description of the issue/s.	D1527 was suffering from Major Depressive Disorder and Post Traumatic Stress Disorder while he was detained at IRC Brook House and continues to suffer from those conditions today. He was on psychiatric medication when he arrived at the IRC. The diagnosis was confirmed by Dr Thomas in her report dated 31 May 2017 (HOM002997) and Dr Basu in a report dated 27 December 2017 (CPS000011). IRC Psychiatrist Dr Belda also separately diagnosed D1527 with PTSD on 2 May 2017 – this is recorded in his IRC health records in an entry by Karen Churcher on that date.
103.	In your view, what caused these issues (e.g. accident, self-harm, previous experiences in home country, detention etc).	These issues are addressed in the medical reports of Dr Thomas and Dr Basu.
104.	How would you describe the healthcare you received at Brook House? Please provide as much detail as possible (i.e. approximate dates, who provided the care (e.g. nurse, doctor,	In short, it was inadequate in triggering release and it was inadequate in managing his condition while in detention. Please see the statement of facts and grounds as to why it was said his detention was rendered unlawful by reason of the failures of medical practice. Please see

	in the Centre, in hospital etc).	detailed pleadings as to why it is said that his treatment in detention was inhuman and/or degrading and violated article 3 ECHR in part because of the woeful inadequacies of medical care and support. This is an issue at the heart of the case and will be addressed in closing submissions. In relation to the remaining questions about medical treatment, details about D1527 treatment can be found in his medical records (CJS005997).
105.	Please consider documents CJS001124 pg 13 (entry at 22:11 hours) and CJS000611 pg 3, which record that you had superficial cuts to your left upper arm, and were advised to bookto see a doctor. The notes record medication issues and that you were not sleeping well. xxxiv. Do you recall having medication issues at this time? If so, what were the issues? xxxv. Did you have problems sleeping? Were they addressed? xxxvi. Did you see a doctor about these issues and if so, what happened?	Please see the medical report of D. Basu. See paragraphs 33-38 of the WS.

106.	If you received treatment from a healthcare professional, please describe that treatment (forexample): *g.* How easy did you find it to access medical care? *h.* Was there any reason why you didn't access medical care where you needed it? *i.* Please describe how any medical issue was treated. *j.* Were you provided with an interpreter if you needed one? *k.* Did you experience any issues or delays with receiving medication or treatment? i. Please consider document CJS001025, relating to 15 May 2017, on page 10, which states that you ran out of medication a few days ago, a doctor had completed a new prescription, but the medication had not yet arrived - is this accurate? ii. Please consider document CJS001025, relating to 15 May 2017, on page 10, which states that you complained that an appointment with RMN on 22 May was too far away, and that you were	D1527 has addressed these issues in his witness statement at paras 26, 40, 85-86, 118 and 147-8 , where he describes how he feels about the medical treatment he received at IRC Brook House. The standard of healthcare and its relation to decisions whether to maintain detention is a core theme addressed above, and in his evidence. In relation to the remaining questions, details about D1527 treatment can be found in his medical records (CJS005997). The issue about medication referred to in CJS001025 appears to have been resolved. The issue was raised with Nurse Morley on 16 May 2017 who booked an appointment in for D1527 for the following day. D1527 saw Nurse Churcher on two occasions on 17 May 2017 and in the medical records at 16.28 it appears that a change was made to increase D1527 medication (CJS005997 pg. 47 and 48). D1527 did not frequently request paracetamol. As his witness statement explains at …, the response to Healthcare staff to almost any problem was to offer paracetamol. HOM032221 is a reference to D1527 witness statement rather than any medical record. It is not clear what is being referred to, but D1527 discusses panic attacks and feeling tingling in his extremities following mistreatment in his witness statement at … In relation to SXP000145, D1527 police witness statement, D1527 reported remarks made by staff which either directly or impliedly stated that he was malingering. D1527 memory of those comments

	advised to go and see if it could be brought forward. Is this accurate? And were you able to? iii. Please consider document CJS001025, relaring to 15 May 2017, on page 10, which records that you complained that you often forget appointments and asked to be reminded, and that you were told that you are responsible and suggested an alarm on your phone. Is this accurate? Did this resolve your issue? iv. The records show that you frequently sought paracetamol - why was this? Were you provided with paracetamol as required? *l.* Save as set out above, were you referred for additional or specialist treatment? i. Was this done promptly or with any delays? ii. Where were you referred? *m.* Were you satisfied with your treatment? If not, why	reflects a general lack of empathy towards D1527 by staff in IRC Brook House and are similar to comments about D1527 by staff recorded in Callum Tulley's secret footage. CJS001035, HOM000414 and CJS001153 all concern statements of suicidal intent made by D1527 At no point did Healthcare staff initiate the process of obtaining a Rule 35(2) report to inform the Home Office that D1527 was expressing suicidal intent, as required by the Detention Centre Rules 2001.

	not? *n.* How would you describe the attitude of healthcare staff? *o.* Nurses ii. GPs iii. Psychiatrists iv. Others? i. Did you feel that your healthcare issue was treated seriously? j. Please comment on the following entries in your records: i. Document HOM032221, pg 90: It is recorded that you asked for a nurse, and felt you were having a heart attack: i. Can you recall who the nurse was? ii. When was this? iii. Had this happened on other occasions?	

	iv. if so, how often did you have these sorts of symptoms? ii. Document HOM032221, pg 91 [21]: It is recorded that staff used force against you, that you felt something tingling in your arm, chest, legs, and that a nurse said this is what happens when you have a heart attack, but didn't do anything about it i. Can you recall who the nurse was? ii. When was this? iii. Document SXP000145 - your statement to the police, in which you say that one day within the first 15 days you tried to harm yourself and staff said *"this guy is playing"* and *"just doing it for attention"*. Do you have anything to add to this? iv. Please see document CJS001035 pg 12 entry on 21 April 2017 at 17:51 in which you said you wanted to die.	

	i. Do you recall saying this? ii. Was this correct? What was done? *v.* Document HOM000414 pg 15 at 19:00: "*says that he doesn't want to be seenby healthcare in the morning or anyone else as it stresses him out"*, and at 19:15, to *"take him to hospital or bury him"* i. Do you recall saying this? ii. Did seeing healthcare stress you out? why? iii. Do you have any further comments? *vi.* Please see document CJS001153 at pg 5, which records "*He stated that he said he was going to kill himself out of frustration over several things includingseeing the doctor"* i. Do you recall saying this? ii. Is this correct? iii. if so, why were you frustrated about	

	seeing the doctor?	
107.	Did you trust the medical professional that treated you? If not, why not?	D1527 had little choice but to engage with Healthcare at IRC Brook House because he had no other option for obtaining essential medical care. The evidence demonstrates that no member of the Healthcare team managed to win D1527 trust and build a good rapport with him while he was detained at IRC Brook House. See WS at paras 26, 40, 85-86, 118 and 147-8 , D1527 lack of trust if Healthcare staff was entirely justified. For example, shortly after D1527 arrived at IRC Brook House, Karen Churcher told him that reporting self-harm to Healthcare would make it less likely that the Home Office would release him, encouraging D1527 to avoid reporting symptoms to Healthcare. Not only was that advice a breach of her duties as a nurse, it was also an erroneous description of the law. Duncan Lewis made a complaint to the Home Office about this on 27 April 2017 but no action was taken (HOM000241)
108.	Did you feel that the healthcare teams were independent of the Home Office/G4S?	No, D1527 did not feel like Healthcare were independent of the Home Office and G4S. See WS at paras 26, 40, 85-86, 118 and 147-8 , Healthcare actively colluded in the mistreatment of D1527 by staff, most notably when Nurse Jo Buss failed to report the use of force against D1527 by Yan Paschali and entered false information into his ACDT records to cover up the assault on 25 April 2017 and when Nurse

		Karen Churcher took part in mocking D1527 while he was on the netting on 4 May 2017. There were close personal relationships between Healthcare staff and detention officers. It is clear from the Callum Tulley video footage of staff interacting that Healthcare staff did not consider themselves distinct from Home Office or G4S staff or consider it necessary to maintain their independence. D1527 legal team are aware that Stephen Dix, one of the IRC Brook House staff members who mistreated D1527 on 4 May 2017 was married to Jacintha Dix who was a Gatwick IRC healthcare practice manager during the time D1527 was detained at IRC Brook House.
109.	Further medical notes are at document CJS001002, please provide any additional relevant comments.	The document reference in this question does not correspond to a document. In any event, it is difficult for D1527 to remember granular details about events over 4 years ago.
110.	Please consider document SXP000057, which is a BBC Annex document. At pg 10, lines 26-27, the document states that on 06 June 2017, you said you wanted to be permanently isolated and kept away from other people. It sets out that this appeared to be the result of your psychological decline in detention. xxxvii. Is it correct that you said that you wanted to be permanently isolated?	D1527 cannot remember making this comment, but it is plausible and the BBC would be correct to attribute it to psychological harm caused by detention. By this point, Dr Thomas had already provided a diagnosis, stating: **D1527** *currently presents with psychiatric symptoms of Major Depressive Disorder secondary to his past and current life circumstances, with a secondary diagnosis also of (complex) Post-Traumatic Stress Disorder (PTSD). His depressive condition is currently rated as severe with acute suicidality and his PTSD moderate-severe*" (HOM002997).

	xxxviii. What happened next? xxxix. Why did you want to be permanently isolated?	D1527 was released from detention shortly afterwards. It should be clear from the context that D1527 did not want to permanently isolated from other people. During his time in detneiton he had repeatedly stated the opposite and it is clear that time spent on Rule 40 without any association caused D1527 huge distress. This comment could only have been made while D1527 was experiencing severe depressive symptoms and had lost all hope. He made other similar remarks about remaining at IRC Brook House forever earlier during his time in detention. D1527 comment should not be used to minimise the harm caused to him by being separated from other detainees.
111.	Did you make any complaints about the healthcare you experienced at Brook House? xl. If so, please describe the complaint made. Please include who it was made to and whatdid you say. xli. What was the response? xlii. Were you satisfied with the response?	D1527 frequently expressed his view that he was not being treated well at IRC Brook House, but he was not directed towards any complaints system. His solicitor frequently raised concerns with the Home Office and IRC Brook House about Healthcare's failure to issue a Rule 35(1) or Rule 35(2) report. This has been set out in the witness statement and repeatedly above.
Complaints and Oversight		

112.	i. Do you know about the following: i. PSU (Professional Standards Unit) ii. IMB (Internal Monitoring Board) 1. How were you made aware of them? 2. Did you view them as independent of the Home Office/G4S 3. How could you complain to them, if you wanted to? 4. Were the IMB complaints boxes clearly visible in the Centre? 5. Save as already set out above, did you ever speak to IMB visitors in person?	**The PSU** D1527 was not aware of the PSU and their role at the time of his detention, however they investigated his complaints post-Panorama. The PSU's investigation was inadequate and lacked independence. It was an entirely closed investigation that had little regard or focus on D1527 as a victim. The PSU ignored D1527 written complaint of 21 September 2017 and instead focussed on terms of reference issued by the Home Office Detention Services – one of the departments that D1527 complained of. D1527 was denied access to the underlying evidence considered – such as CCTV, body cam footage and the interview transcripts taken from officers. The PSU failed to interview key individuals such as DCM Steve Dix, and DCOs Fraser, Francis, Shaukat and Bromley, or Nurse Jo Buss. DCO Paschali was only interviewed by chance because he was attending the PSU for a different investigation. They relied upon internal G4S disciplinary interviews instead of interviewing officers about D1527 specific complaints. The PSU failed to give any adequate scrutiny to the entirely conflicting statements of officers in respect of the 4 May 2017 incident. They also failed to identify that other officers were present during this incident and interview them accordingly. The investigation was too passive to G4S officers and failed to put any scrutiny on them. The PSU's approach was to entirely disbelieve D1527 unless there was specific Panorama footage to back up his claim, and to believe DCO use of force reports and interviews with any scrutiny.

		6. What about? 7. Were the IMB forms (for detainees to write complaints on) widely accessible on the wings? 8. Were you aware that complaints made to IMB may be shared with G4S and/or the Home Office? 9. Did you ever complain to the IMB? If so, when, what about, how was it dealtwith, were you satisfied with the outcome? iii. PPO (Prisons and Probation Ombudsman) iv. Chaplaincy v. Gatwick Welfare Detainees Welfare Group	The PSU reported their investigation to Home Office Detention Services – i.e. one of the bodies complained about – and the report was not shared with D1527 Instead the Home Office Detention Services prepared a limited summary of the report's findings. We understand that this is standard practice for PSU investigations which is highly concerning in that it results in the victim not being fully informed of the outcome, and one of the key accused organisations (the Home Office) being given the entire findings. This means PSU investigations are in reality closed and internal Home Office reviews of their own conduct and can be deemed an adequate or functioning independent complaints process. D1527 was only able to obtain the PSU report, not normally disclosed to victims, through pressing for it in his judicial review proceedings – the PSU and Home Office would otherwise have denied him access to the report. D1527 repeatedly requested the underlying evidence to the investigation from the Home Office and specifically the PSU. D1527 was denied these documents meaning his subsequent appeal to the PPO could not be an informed one and blind of the evidence that was used to make the PSU's findings. Requests for these documents from the PPO were also left unanswered. There are significant failings of transparency and equality of arms in the complaints process through the PSU and PPO. D1527 has only now been able to review the full extent of the evidence because his case was so severe and he fought his case successfully in the High Court as to require a full public inquiry. This is obviously highly unusual and unique circumstances that have led to D1527 being

		able to access the underlying documents. The Inquiry must urgently review the transparency of the PSU/PPO complaints process and how detainees are given a greater role in the process and are given an opportunity to review the underlying evidence. At present detainees are complaining to a body which is not independent, which undertakes a closed investigation into allegations in closed institutions. D1527 extensive correspondence with the PSU and PPO can be found at DL0000129. We also enclose the first witness statement of Lewis Kett dated 17 September 2018 from D1527 & D687 *v SSHD* [2019] EWHC 1523 which has previously been provided to the Inquiry but has not yet been made available to core participants on Relativity. More detailed criticism of the PSU complaints process and its lack of independence can be found at paragraphs 18 to 41 of that witness statement. **The IMB** D1527 cannot recall discussions with the IMB or their role. As we have set out in response to question 94 above, the IMB were not an effective oversight mechanism in D1527 case. They were not capable of picking up on the abuse and assaults D1527 suffered, nor were they able to pick up on the full extent of D1527 mental health deterioration or his suicide attempts, or they were unwilling to properly report on any concerns to the Home Office. The Inquiry should fully investigate the extent to which the IMB may have present at Brook House on 24-25 April 2017 and 4 May 2017 and whether they had any knowledge of the incidents on that date.

113.	If you were aware of any of the above organisations: vi. What do you know about this organisation/these organisations? vii. What were you told by staff? viii. What were you told from other detainees or visitors?	See response to question 112
114.	During your time and Brook House did you make any complaints or raise any concerns about your own treatment or that of others, including to staff, to one of these organisations, to the police, or to anyone else?	As set out in response to question 112 above and 120-121 below D1527 made complaints to the PSU and the police in the immediate aftermath of Panorama. Duncan Lewis made regular complaints to the Home Office, healthcare and G4S about D1527 detention, failures to produce Rule 35s and decisions to segregate – including: • Letter to Home Office on 5 April 2017 requesting a Rule 35 be completed upon his arrival at Brook House (HOM00101_0005); • Letter to Home Office on 6 April 2017 seeking release from detention and concerns about D1527 unsuitability for detention (HOM000345) • Letter to Home Office on 13 April 2017 complaining about the Rule 35(3) report issued by Dr Oozeerally which failed to comment on impact of detention despite being required to do so by policy

		• Letter to Home Office on 26 April 2017 setting out complaints and concerns in respect of his continued detention and fact he was food refusing, on ACDT and expressing suicidal ideation. A request was made for an urgent Rule 35(1) (HOM000241) • Letter to Home Office on 27 April 2017 complaining about inappropriate comments made by Nurse Karen Churcher about D1527 and the reporting of his mental health symptoms and self-harm/suicide risk and concerns that the brook House healthcare team could not manage D1527 complex mental health needs (HOM000241) • Letter to Healthcare on 27 April 2017 requesting that a Rule 35(1) report is urgently completed noting D1527 continued food refusals and active suicidal intent. Clinical lead Chrissie Williams responded on 28 April 2017 stated "D1527 *has had a rule 35 completed on 13/4/17 and was sent to home office that day and they have responded to this."* This demonstrated a complete lack of understanding by Brook House healthcare in respect of the difference between each Rule 35 report and so we emailed them on 28 April 2017 setting out the difference between Rule 35(1) and Rule 35(3) and why the former was required. • Pre-action letter to the Home Office on 31 May 2017 serving the psychological report of Dr Rachel Thomas and explaining why D1527 detention was unlawful and why he should be urgently released given that detention was deteriorating his mental health. (HOM000484)

		eventually cumulating in judicial review proceedings for unlawful detention being issued (DL0000119)
115.	If you did, please provide details: ix. When you made the complaint; x. To whom? xi. Was the complaint resolved? xii. What was done? xiii. Were you satisfied with the response and why; and xiv. Do you feel that you were treated any differently due to fact you had made a complaint?	See above response at 114
116.	If you did not complain about your treatment (but wanted to), what prevented you from complaining? (e.g. previous experience of lack of effectiveness of any of the complaints system; lack of awareness of how to make a complaint; lack of trust that it would be resolved/taken seriously etc).	See above. D1527 was able to submit complaints about various aspects of his detention through Duncan Lewis where we readily had available information about his mental health, suicide risk, segregation etc. However it was clear that D1527 was so traumatised and unwell at Brook House that he did not feel safe complaining directly about many

		aspect of his detention. Karen Churcher's comments on 21 April 2017 reflect why he distrusted healthcare. The extent of the abuse against D1527 did not come out until after Panorama – he was too traumatised to disclose this to his solicitors or friends that visited him or Dr Thomas who saw him at Brook House in May 2017.
117.	Please consider HOM000195 at pg 93 [31], which states "I *never felt like I could talk to anyone or make any complaints about what was happening to me. I had made a complaintin prison but no one took anything seriously. The staff at Brook House were the same, I felt like I could not say anything as it would just make things worse for me"* i. Is this correct? ii. Did you consider complaining to PSU, IMB etc - if not, why not? iii. How and why did you think things would get worse?	See D1527 witness statement at paragraphs 48 (extracting statement of 19 January 2018) See responses above at 112 about the PSU and IMB
Police		
118.	Save insofar as already set out above, did you make any complaints to the Police about anytreatment you received at	Yes

	Brook House?	
119.	If so, how did you make it? (i.e. directly by contacting the police or by lodging a complaintthrough another body who then referred it to the police)?	A written complaint was submitted to the police on 21 September 2017 by Duncan Lewis solicitors following the broadcast of the Panorama documentary (DL0000132_0042). We understand that Sussex police had already commenced an investigation.
120.	What was the complaint about?	The written complaint was sent on 21 September 2017 and sought an urgent investigation into criminal activity against D1527 in respect of the incidents broadcast on the Panorama documentary on 4 September 2017 . The letter summarised this criminal activity as follows: *"The three incidents appearing in the documentary related to our client comprise:* *(a) Footage of an officer employed by G4S at Brook House Immigration Removal Centre called "Calvin" boasting that he had hit* **D1527** *head against a table and bent back his fingers. This features at between roughly 21 minutes and 24 minutes into the documentary. We believe the incident to which he refers may have been on or around 9 April 2017.* *We believe that this incident points to common assault or ABH against our client and that there was, after the assault, a deliberate decision not to report the assault which should be*

		regarded both as aggravation of the initial crime and as further criminal conduct. *(b) Footage of officer Nathan Ring (employed by G4S) mocking our client when he has a phone battery in his mouth; an officer called Yan Pescali then kneeling over our client with hands around his neck choking and verbally abusing him and saying ""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 ya? Are you going to stop being an idiot? Yes or no? Yes or no?" (while strangling our client)" ; that officer then directing the nurse not to write up the incident; and officers talking about the incident in a derogatory way afterwards. This incident features at between roughly 46 and 53 minutes into the documentary. The incident occurred, according to the client's medical records, on 25 April 2017. We respect the police's judgment as to what specific crimes may be charged, but we believe this incident involved potentially the following:* *G**BH with intent** contrary to section 18 or section 20 of the OAPA 1861. The very serious psychological impact of the threat to put our client to sleep being particularly relevant here. There is considerable medical evidence of the adverse impact of this assault. Our client was released from detention shortly afterwards in view of acute and severe suicidality. **Threat to Kill** contrary to section 16 of the OAPA 1861 We believe that those guards who were present at the incident*

		can be seen as having encouraged, ***aided and abetted*** *the assault* *There was then a conspiracy among several guards present, and the nurse to cover up the incident in that it was not written up in notes and the relevant protocols were not followed."*
121.	What was the outcome of your complaint?	Following the complaint, D1527 was interviewed by Sussex police on 29 September 2017 at our Duncan Lewis offices. In emails dated 9 October 2017 and 11 January 2018 investigating officers confirmed the investigation was going 'slowly' (DL0000132_0046). On 17 February 2018, the investigating officer, Detective Constable (DC) Steve Trott, confirmed that Mr Peschali was the only G4S officer who has now been interviewed under caution. On 22 February 2018, we wrote to the police setting out our concern that the scope of the criminal investigation was limited to Mr Paschali and actions committed by him alone (DL0000132_0047). We sought clarification on whether the police would be considering charging the detention officer, Kelvin Sanders, who admitted on camera to assaulting our client, charging Nurse Joanne Buss who agreed not to record the assault by Mr Paschali in her medical notes, whether they would be charging the several officers present as either principles in

		that they formed those assaulting D1527 or as aiding and abetting the assault, or charging all of those individuals officers and the nurse with misconduct in a public office. An initial reply was sent by Detective Inspector (DI) Andrew Richardson by email on 27 March 2018 confirming that a further meeting had been arranged with the Crown Prosecution Service (CPS) in early April. We responded by email on 28 March 2018 asking whether the CPS were being consulted regarding Mr Paschali alone or also regarding the further issues raised in our letter of 22 February 2018. On 30 April 2018, DI Richardson responded confirming that he had met with the CPS reviewing lawyer on two occasions (DL0000132_0054). They provided the following response: *"a) I have decided that no further action will be taken against 'Calvin'. Whilst he admitted on camera to the assault there was no supporting evidence to say this occurred. He was interviewed and denied the allegation stating that the assault did not happen but what he said was all bravado; he was trying to fit in with others at Brook House so that he wouldn't be bullied himself. In addition your client has no recollection of the incident and there were no*

		witnesses to it so there is insufficient evidence for a successful prosecution. *b c & d) The CPS are continuing to review the evidence in relation to the allegation of assault on your client and in the light of this, until they have formally advised, it would be inappropriate for me to comment further."* A further update was received from DC Trott on 4 July 2018 by email stating that he had met with the CPS the Friday before (29 June 2018) seeking documentation on any psychological harm caused by Mr Paschali's actions, and to seek an update on D1527 immigration matter. This information was provided to DC Trott by email on 6 July 2018.. DC Trott provided updates by email on 23 July 2018, 30 July 2018 and 24 August 2018, all confirming that no decision had yet been taken by the CPS. Finally on 7 November 2018 – 14 months after Panorama aired – the CPS wrote to us confirm that no charges would be brought against anyone in respect of D1527 treatment at Brook House (DL0000132_0060). The Senior Crown Prosecutor stated:

		"Specifically I considered a charge of assault occasioning actual bodily harm. To prove this offence it is necessary to show that some injury can be attributed to the suspect. I noted that there was evidence of reddening to your neck having been recorded. However there was insufficient evidence of a specific injury which could be attributed to his actions. In particular I am aware that you had been attempting to self - strangulate before the incident and therefore the difficulty would be in proving that the redness observed to you neck was as a result of the suspect's actions as opposed to this earlier incident. *Alternatively I did consider whether the suspect could be prosecuted for an offence of common assault. However this offence must be charged within 6 months of the commission of the offence. This time limit had already passed by the time the Sussex Police referred the investigation to the CPS for consideration. We were therefore unable to bring charges for common assault.* *I also considered whether the suspect could be charged with Misconduct in a Public Office. This is a very serious offence. There is case law to the effect that the threshold for assessing*

		the actions of people such as the Detention and Custody Officer is a high one. Further that the conduct in question must be worth of criminal condemnation and punishment. The appropriateness of charging this offence in the particular circumstances of this case was considered very carefully…. After consideration of her advice and after consultation with senior legal managers I concluded that in respect of the single incident on 24th April that I was asked to consider, taking into account the whole of the circumstances of the Detainee and Custody Officer's conduct, there was insufficient evidence to provide a realistic prospect of conviction for this offence." The CPS's response essentially confirmed that DCO Paschali was not charged with common assault because the six month time limit for common assault had passed (25 October 2017) by the time the police referred the case to the CPS. This is a grave error of judgment by the police in not investigating the office quickly enough. The CPS also confirmed they would not charge Paschali with ABH because D1527 had been self-harming and so they could not attribute who caused the injury to his neck. This despite their being several witnesses, video footage of the assault and video evidence of the effect it was causing D1527 A detailed victim request for review was lodged with the CPS on 26 November 2018 ((DL0000132_0063) noting our above concerns as

		well as making an official complaint against the police for failing to investigate the assault/battery within the 6 month time limit – DCO Paschali was interviewed at his own leisure as opposed to arrested immediately following Panorama. We also set out concerns that insufficient explanation was provided on the misconduct in public offence, or the wider context, or that no officers or staff were considered for criminal offences other than Paschali despite a clear conspiracy to cover up the assault against D1527 The CPS responded to the Victims' Right to Review on 10 December 2018 maintaining the decision not to prosecute (DL0000132_0070). That letter confirmed that although Callum Tulley provided a statement to the police, "others present refused to provide statements to Sussex Police when requested" – there was no indication that they were arrested. On the common assault time limit passing, the CPS stated that "this is a complaint that should be pursued directly with Sussex Police". The decision on misconduct in public office was also maintained on the basis of "the very high bar required to prosecute this offence." As to why other officers were not considered for criminal offences, the CPS confirmed the police had not referred matters to them and that the police had taken a decision that "those matters not proceeding further". A full review of the decision was sought from the CPS Appeals and Review Unit on 2 January 2019. This was D1527 last opportunity to have the decision not to prosecute be reviewed. Whilst a decision was awaited from the CPS, a complaint was filed on behalf of D1527 to Sussex Police on 4 March 2019 for their failure to investigate the

		common assault offence against DCO Paschali within the 6 month time limit (DL0000132_0080). On 19 March 2019, a final CPS victim review was received from Specialist Prosecutor C.Pickering maintaining the decision and providing further explanation as to why misconduct in public office could not be pursued (DL0000120). Having noted evidence from Callum Tulley that Paschali applied a 'phenomenal amount' of pressure on D1527 neck for about 6 seconds, and Jon Collier's statements which described Paschali's actions as "deliberate and not a simple misapplication of an approved pain-inducing technique." However the Prosecutor went on to justify a prosecution should not be brought on the basis of the volatile and toxic atmosphere in Brook House: *"On the other hand, an assessment of the context in which the alleged misconduct occurred is an important consideration of seriousness. This is a difficult environment for all concerned. It is equally clear from the footage that some of the detainees are violent and volatile, attacking both each other and staff. The context of this behaviour is that Brook House can be an unpredictable place to work with self-harm and suicide attempts being rife. It is a toxic atmosphere that can erupt into violence in seconds. The background is that earlier that day, your client had threatened suicide, saying he would cut himself; he put batteries in his mouth, he was headbutting the viewing panel to his room, he attempted to hang himself and self-strangulate, and told the staff they would have to use force*

		to move him back into E Wing. He was low and angry by his own admission. *There is a crucial obstacle to bringing a prosecution for misconduct in public office and that is in respect of the issue of the phone batter. Your client accepts that he had a battery in his mouth and thinks he had attempted to swallow a battery twice before whilst art Brook House. The suspect says that he knew your client had a battery in his mouth and that he had already save your client's life twice that day. The suspect had taken razor blades, ligatures, a lighter and a phone battery off him. The suspect says he believed your client was choking and was trying not to allow your client to swallow. He says your client was gurgling because of what he had in his mouth i.e. a battery…* ***The suspect's words and actions must be judged not against the norms of everyday society, but against the atmosphere of brutality and unpredictability that pervades Brook House and the self-harming history of your client of which the suspect was acutely aware.**"* D1527 had no further recourse to challenge the CPS' decision further as this was the final review. Sussex police responded on 8 April 2019 dismissing D1527 complaint for the failure to investigate the common assault within the 6 month statutory time limit (DL0000120_0007). The Sussex police investigation essentially found that the

		police investigators were correct to treat the investigation against DCO Paschali as being one of ABH.
122.	Was it dealt with to your satisfaction?	The investigation into criminal offences against DCO Paschali and other officers was wholly inadequate and the police and CPS completely failed D1527 as a victim. D1527 exhausted his options to review the decisions and complain against how the investigation was conducted. There was ultimately no prosecution against DCO Paschali because the police believed they were investigating an ABH and the CPS believed it was a common assault. There was no urgency to arrest and investigate DCO Paschali by the police. And there was insufficient discussion between the police and CPS immediately as to whether ABH needed to be ruled out and whether, in caution, a review of the common assault should have been completed in time. The CPS' final review of misconduct in a public office on 19 March 2019 is alarming and requires consideration by the Inquiry as to the nature of the claims made by the prosecutor about Brook House. The prosecutor comments suggest that officers at Brook House should be held at a lower standard and given more leeway to commit criminal actions because of the "atmosphere and brutality that pervades Brook House" and because the victim had a history of self-harm. This suggests a prosecution could have been brought if our client was less vulnerable and if Brook House was a less problematic and volatile centre. This appears to be a complete failure as to the public standards required of public servants (namely detention officers) who should in

		fact be held to a much higher standard, and is the basis of why misconduct in public office is such a grave crime.
General Conditions		
123.	How was the state of cleanliness of the Centre?	See references at 129 below of other detainee complaints about cleanliness of cells which reflect D1527 experiences
124.	Do you have any observations about the food provided? (in relation to the amount of foodprovided, quality and variety) xv. Please refer to CJS001035, where it is reported that on 17 and 21 May you statedthat you did not like Brook House food and that it upsets your stomach 1. Is this accurate? 2. What did you not like about it? 3. What about it upset your stomach?	D1527 food refusal was attributable primarily to his mental distress but the quality of the food did not help either. He has no specific recollection or any further to add.

125.	Was the temperature of the Centre adequate (i.e. not too hot or too cold)?	See references at 129 below of other detainee complaints. It was generally accepted by both those held and working at Brook House that the centre lacked fresh air, was hot and lacked ventilation
126.	Were toilets generally fully or partially separated from the rest of the room? *xvi.* Please refer to HOM000195, pg 91 [23] which records *"The toilet did not have a door, if you needed to go to the toilet you would have to do this in front of the people you were sharing a room with"* xvii. Is this accurate? xviii. Was this the case in each room you stayed in?	This statement is accurate and his understanding of each of the rooms in which he was sharing with other detainees. This was a common complaint by several detainees at Brook House – see complaints of detainees at DL000005 at 3-9, 54-61, 90-110, 143-165 and the witness statement of Callum Tulley at 48-53