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D668

Sent to GLD to issue

Dated:

Dear D668,

I am writing in response to your representatives, Duncan Lewis, Letter Before Action letters dated 19 and 29 September 2017.

I would like to thank you for meeting me on 20 December 2017 at Lunar House, Croydon and providing your full recollection of your time in Brook House Immigration Removal Centre (IRC) and your concerns about your treatment there.

ALLEGATION 1: that on 29 June 2017, prior to leaving your room, DCM 01 was rude to you saying "pack your stuff and get out!" You were later mocked by G4S officers when you returned to Brook House IRC reception following a failed removal.

You said that you had been moved to Brook House IRC on 28 June 2017 and had been told that you were to be removed on 29 June 2017. You said that you had been told to pack your belongings at 08:00 hrs by a Detainee Custody Officer (DCO) and had remained in your room. You had been told a second time by Detainee Custody Manager (DCM) 01 at 10:00 hrs and when you asked for more time had been told "*get your stuff and get out there.*"

Whilst DCM 01 could not recall this incident, the roster showed that he had been a wing officer on the Induction Wing (B Wing) on 29 June 2017. He said that you would have remained on B Wing in readiness for your removal. So, both of you were on B Wing at the time of the alleged incident.

Given the IS.91 form for your removal showed that Tascor had collected you from Brook House IRC at 10:30 hrs for your 16:15 hrs flight to Cote D'Ivoire, it is

reasonable to assume that you needed to be in the discharge area rather than your room. You asking DCM 01 to wait a minute given the timescales could have escalated the situation to the point that DCM 01 felt he had to be direct to encourage compliance.

However, the fact is you said that this happened and you had felt *"shocked"* about the manner in which you had been spoken to. DCM 01 could not recall this incident. There were no witnesses. Given there was another incident between you both on the Visits corridor, this will be **held in the balance** and considered alongside the other complaint.

The Movement Order (MO) was cancelled at 15:43 hrs. and you were signed back over to Brook House IRC responsibility at 17:30 hrs. The roster showed male DCOs 01, 02, 03 and a female DCO 04 on duty. All the reception officers were consistent in their accounts in relation to not remembering you or the event and given this was eight months ago this was accepted as a reasonable response. They were consistent that the behaviour described by you would be *"weird"* given there were often failed removals so it was a normal occurrence and would not affect such a response as *"oh he's coming back."*

I was satisfied with this response, being aware that detainees are often returned following failed removals. All said that other officers could have been present and made the comment but none had heard such a comment. I was satisfied from your evidence that it had been two male DCOs on the reception desks.

However, the way in which you displayed your upset during interview was moving. I appreciate that you had had a very upsetting and stressful time during the attempted removal and from your full description of this. This could have affected your perception of your reception back into Brook House IRC. You were already very emotional on your return. I have balanced this with the fact that DCO 04 was a witness and she raised no concerns regarding her colleagues' actions and two independent Tascor officers had been present as you arrived and recalled no incidents. I would have expected them to comment if you had become more upset. I have also considered the officers' response to how upset you said that you were about how you had been treated and the empathy they displayed. On the evidence and to a balance of probabilities, I do not find that you were mocked by G4S officers when you returned to Brook House IRC reception following a failed removal. This allegation is **unsubstantiated.**

Allegation 2: that on 12 August 2017, a detainee threw a bucket of water on you and your friend which you reported to a G4S officer but no action was taken.

In your original witness statement and your representative's letters of 19 and 29 September 2017, you said that the incident when water was poured on you in the dining area was the second week of or mid August 2017. At interview, you confirmed that date was 12 August 2017 as provided by your friend who had been with you D450 D450. Although unclear on the date initially, you were very concise about the actual incident and the officer you reported the incident to. D450 was consistent in the main about what had happened the day water had been poured on them both.

DCM 02's evidence was mainly consistent with you and D450 I was satisfied that on a date in August, detainees (s) had poured water from the second floor onto the diners below that included you and D450 and you and a number of detainees and their food had been covered with water. You and these detainees had complained to DCM 02 and he in turn had escalated this, fearing a repercussion of unruly behaviour and being new into the role. Some managers had become involved and spoke to the two perpetrators. They had decided to monitor the situation. You and the affected detainees had been told G4S were dealing with the incident.

I accept DCM 02's rationale why the names of the perpetrators were not disclosed to you and the group of rightfully angry, upset detainees. However, concerning was the lack of documentary evidence to support the incident had taken place, what investigation had taken place, the outcome and feedback to the 'victims.' This was unfortunate, given how clearly DCM 02 recollected the incident and the investigation that he said had taken place. DCM 02, you and D450 were consistent that feedback had been given and whilst this was not what you had wanted (i.e. not the perpetrator names) it was sufficient feedback and in line with the G4S Violence Reduction Strategy.

Turning to the lack of records about the incident, Detention Service Order (DSO) 11/2014 states that Serious Incident Reports (SIRs) 'are written by any person who has information of value, in their opinion, to the security of the establishment. They are collected by the IRC supplier and are fundamental to the dynamic intelligence process collated within the establishment by the Security Department.' Given DCM 02's concerns that the incident could "*instigate a further mass brawl*" and he had been the officer approached by the detainees, he should have completed a SIR. He said that he had expected managers to do so, but the guidance is clear that it is up to anyone in the establishment. I do not accept DCM 02's reasoning about not completing the SIR form.

SC 01 provided advice from his role in security. He said that when security received a report, they would go to the control room and view the cameras. They would create a timeline, identifying the detainees they could and then submit their report to the security manager. The Incident Report (IR) had 16 boxes and the incident would have to fall into one of these; in this case, assault of a detainee. It was a factual account of something that had happened. The form guidance stated the first on scene (DCM 02) should have instigated the report. All others present (managers who attended) should have completed Incident Statements (IS) as witnesses. DCM 02 should have completed an IS as well as instigating the IR.

If the incident did not fall into an IR then it should be reported on an SIR as a belief / suspicion. SC 01 had checked and there were none of either for you. SC 01 checked and there were also no observations on the G4S database. There should have been if the incident had been reported. The G4S database record for you made no mention of any events concerning water or indeed anything in August 2017. It was very sparse.

DCM 02 named one of the perpetrators so security was also asked to check his G4S database record. Worryingly, there was nothing there either. Exhaustive checks with the Control Room found the logs of who had viewed the Closed Circuit Television

(CCTV) in August 2017 as unavailable. Based on the evidence and to a balance of probabilities, I have found that none of the staff who attended the incident in August 2017 completed the requisite forms and records that they should have. No investigation of the incident was completed, given the absence of any documents to prove otherwise.

Other than the establishment security procedures that had failed on this occasion, I also reviewed the G4S Violence Reduction Strategy. This defined violence as 'any incident in which a person is, abused, threatened, or assaulted. This includes an explicit or implicit challenge to their safety, well-being or health. The resulting harm may be physical, emotional or psychological.' The policy invites detainees to complain in a number of ways, one of which is to an officer. The officer should then make a verbal referral to the Oscar 1 and written IR and SIR reports. No-one documented your or the other detainees present accounts'. The officers and managers present breached this policy.

It states 'all Gatwick staff will be trained to respond appropriately and confidently to any incident of physical violence. The level of intervention will always be appropriate to the incident.' The throwing of water onto the diners below was an act of physical violence that according to DCM 02 was capable of leading to a *"mass brawl."* This was still very vivid in the mind of DCM 02 and I would go as far as to state the three managers who attended, given the numbers who did attend and yet it was not documented anywhere.

I have looked at the level of intervention and the decisions made by the managers against the guidance and this states for victims, 'seeking help will be actively encouraged as positive and powerful action by anyone who may become a victim of violence at Gatwick. Detainees will always be given feedback on how the issues have been dealt with. Guidance to staff is 'always acknowledge complaints and grievances and, if possible, try and answer them. They may be totally irrelevant and not based on fact, but you may be able to suggest a solution or compromise that is accepted and, at the very least, you may be perceived as trying to help.' You and your fellow detainees did seek help that day. You were given limited but sufficient feedback on how their concerns had been dealt with.

In terms of the perpetrators the guidance states 'perpetrators will be left in no doubt that their behaviour is unacceptable and will not be tolerated or sustained. We will always seek for reasoned change in behaviour rather than retribution. As well the personal safety of victims we will respect that perpetrator's personal safety will also need to be respected and addressed. Perpetrator's will always be challenged and may be subject to one or several actions.'

None of the actions open to managers were taken. No warnings were issued or any moves instigated. Feedback to you and the other detainees was limited to we are dealing with it but with no visible action.

On the evidence (or in this case lack of it) and to a balance of probabilities, I find that the complaint allegation that a fellow detainee threw a bucket of water on you and your friend, which you reported to a G4S officer but no action was taken **substantiated.** There was no written record of the event, how it was dealt with or

how the complaint was responded to, suggesting the complaint was not responded to.

Allegation 3: that on 17 or 18 August 2017, you were allegedly assaulted by a detainee on D Wing staircase, which you reported to a G4S officer but no action was taken.

You told me that this assault, 'shove on the shoulder', had occurred on D Wing stairs as you were coming down and an 'Albanian detainee' was climbing up the stairs. You said that there were other detainees with this one and that your friend D1249 D1249 had entered onto the D Wing and witnessed the shove and then moved the detainee away from you. There was no CCTV, given it occurred four months prior to the investigation, however, the CCTV would not pick up such altercations as there are areas obscured and blind spots on the staircase. I checked the staircase and the cameras on my visit to D Wing on 17 January 2018.

You told me that you could not identify the detainee and his friends who had blocked and 'shoved' you. You said that the only witnesses you could identify were D1249 D1249 and a DCO called Dember (DCO 05). It is questionable, given the evidence and the regime that D1249 from C Wing would have been able to access D Wing and at that exact time see any altercation and respond to it as alleged by D668 D668. D1249 evidence bore this out. He was unable to give any consistent witness account.

DCO 05 likewise. He said that he had not witnessed a detainee on D Wing stairs 'shove' you and he had not commented as you stated. He was one of the few DCOs who recognised you, given he worked on D Wing sometimes. He was aware you would complain about general things, but had been unaware of any of the complaints being currently investigated. He described the SIR and anti-bullying policies he would have followed if he had been present during the alleged incident. I was satisfied that if DCO 05 had seen the incident he would have recorded it appropriately and mediated between you and the other detainee, as suggested in the Violence Reduction Strategy. You were not complaining about DCO 05's actions in any case.

No IRs, SIRs or G4S database observations were made in respect of this incident. You were unable to describe the security officer you had made your verbal complaint to. The two witnesses put forward were unable to support your account. Without anything more and on the evidence and to a balance of probabilities, I find the allegation that on 17 or 18 August 2017, you were assaulted by a fellow detainee on the staircase, which you reported to a G4S officer but no action was taken **unsubstantiated.**

Allegation 4: that on 24 August 2017, prior to a visit from your brother, you were allegedly 'frisked extremely aggressively' by Darren (DCM 01) and this intimidated you.

You identified DCM 01 from his photograph as the officer on duty when you had had a visit with your brother. Records and persons present showed that you were mistaken on the date of the visit. It was established from the rosters and the

presence of DCM 01 and the description of the female DCO (DCO 06) that this visit had been on 20 August 2017 and not the 24 August 2017 as you had thought. There were five DCOs on duty. DCM 01 had been a manager and not a DCO at this point in time. He had been rostered to cover A and B Wings but said at this time he would sometimes be the manager for all the residential wings when short staffed and indeed on 20 August 2017 the roster supported he had covered four instead of two residential wings. It would then seem unlikely that he would be in the Visits area, given the wider than usual residential role he would have had that day. DCM 01 said that even as a DCO he had been a residential DCO and had rarely covered Visits.

You suggested two witnesses (D4008 and DCO 06) and whilst the female DCO was identified and contacted and D4008 spoken to initially, neither responded to requests for their accounts. There was no CCTV and given this had been four months after the incident, there would be little expectation of any unless an incident had been recorded by an officer. There were no IRs, SIRs or G4S database observations recorded.

You were adamant that the officer who had 'frisked him extremely aggressively' had been DCM 01. He said that "*everyone knew Darren Tomsett was a racist.*" Checks with DEPMU about complaints they had registered (since September 2017) for DCM 01 showed that there had been one of excessive use of force but this had been unsubstantiated in a PSU investigation. G4s Human Resources said that there had been no misconduct investigations for DCM 01.

There had been a detainee complaint in June 2017 alleging DCM 01 was aggressive and discriminated against Black African and Afro-Caribbean's. It was referred back to Brook House IRC by PSU as it had not met the threshold. Race Relations and Diversity Manager (RRDM 01) investigated fully, speaking to the available detainees, DCM 01 and reviewing documents, of which there were none. He concluded there was insufficient evidence of such behaviour. The other six detainee complaints were of a similar nature, 'not friendly…aggressive…racist…unfair' and G4S investigated and found these unsubstantiated. As part of these investigations, PSU investigated a homophobic comment allegation and found this unsubstantiated.

DCM 01 said that he had been accused of being a racist a number of times but had been told that was because he was doing his job. He said he had never been racist and sometimes detainees called officers racist because they did not like the answer the officer had given them. He said racist was a *"loose term that is thrown around in there by detainees against staff."*

Indeed, a few of the officers interviewed across the centre were asked to comment on whether they had seen any verbal or racist abuse by officers towards detainees. They mirrored the sentiment and said the Panorama programme had heightened the use of the word and the threats by detainees towards officers that the detainees would say officers were racist both to get their own way but also to raise false complaints.

Nurse 01 said the same. She said *"detainees did not know the meaning of the word racist."* Last week she had seen a detainee and his first words to her had been *"you fucking big fat black bitch."* She froze. He said *"you don't know what you are fucking*

doing." Two detainees had been stood at the door and she had told this one to get out. These detainees had said that they would have beat this detainee up if he had laid a hand on her. The abuse and spitting was at the officers and not by officers to the detainees. Nurse 02 was South African and being abused for the colour of your skin is not nice. She said she has been called racist several times by detainees. She said *"they use the word for effect. If staff say no then the detainee calls them racist. This word is used to get what they want. Young officers would often give what the person wanted so they are not called racist."*

I considered what you had said about the way DCM 01 had spoken to you on 29 June 2017 and whilst DCM 01 comment had been a direct instruction, I did not find that this had been racist as claimed. On the evidence and to a balance of probabilities, I find that DCM 01 was neither rude nor racist when he had told you to *"pack your stuff and get out!"* The allegation that he was and the findings above that were held in the balance are now **unsubstantiated.**

Even though I doubted that DCM 01 would be in Visits, given his extensive responsibility that day, I have still gone on to examine the alleged search, and compared this with how DCM 01 described a Level A search and the DSO 09/2012 Searching and G4S policy on Social and Official Visits.

Your description was that DCM 01 had squeezed with his hands on your body as he had moved from the top to the bottom of your body. You said you had felt abused. You had questioned the search half way through and DCM 01 had told you to shut up and he was doing his job. You said that you had been searched at Visits before and this had been gentle as the officer had touched your body and searched your pockets.

DCM 01 said that a pat down search would be conducted as a detainee entered and left a visit. He denied the description you provided and said that a pat down search would entail a run across the outline of the arms and run down the side of the torso and then the legs and when the person turns round, the back of the hand down the back and across the buttocks and down the back of the legs. He said you cover all areas not just pat certain areas. He said a level A search would start with the head turning and search around the collar and across the shoulder and then down each arm. He would use the back of his hands down the front. He would use his flat palm as he moved down the side of the body. He would check around the waistband and run his flat palm down the side of the legs. The shoes would be removed and checked and a metal wand may have been used. He was unfamiliar with the Visits process as he tended to work on the Wings.

DSO 09/2012 states, 'the authority for the searching of detainees in immigration removal centres and short-term holding facilities and during escort is contained in paragraphs 2 and 3 of Schedule 11 and paragraph 2 of Schedule 13 to the Immigration and Asylum Act 1999 (the 1999 Act), and rules 7, 50 and 55 of the Detention Centre Rules 2001…Detainees should be searched on entry to and departure from the visits area in accordance with the searching procedures of each service provider...A 'level A rub-down search' is a search of an individual conducted by a single officer running their open hands over the individual's clothing. In addition, the individual removes their footwear for inspection. The officer inspects the

individual's hair by hand and visually inspects the ears, nose and mouth. Hand-held metal detectors and metal detector archways may be used to assist in conducting the search.' (The level B search is the same but without the need to check footwear / hair etc). The Social and Official Visits policy confirms that 'the searching of detainees will take place in visits corridor hall prior to entering and when leaving.'

Based on the evidence and to a balance of probabilities, I was satisfied that even if DCM 01 had been present on Visits and conducted the level A rub down search, which I have already expressed doubt about, then the search that he described to me was the level A rub search required for all visits. It was not as you described. I have also taken into account your intense dislike of being asked to submit to a search, as I witnessed this first hand when I interviewed you at Lunar House. Whilst it is acknowledged that the search process could be found distressing to persons unused to this, it is necessary for the safe and secure running of the centre. Not least given the opportunity for drugs and other items being passed during visits. The allegation that on 20 August 2017, you were 'frisked extremely aggressively' by DCM 01is **unsubstantiated.**

I have considered D668 assertion that the female DCO present (DCO 06) knew what DCM 01 was like but did nothing about this as unfair. Whilst she no longer works for G4S and has not responded to requests for her account, she was a professional DCO and as such would have been bound by the Violence Reduction Strategy as well as her DCO certification. This states that 'those working at Gatwick Immigration Removal Centre have a duty to treat all grades of staff, visitors and detainees with respect and dignity. All members of staff have a duty to report bullying whether it is a series of occurrences or a single incident.'

Allegation 5: that Brook House officers informed the doctor not to complete your Rule 35 Assessment fully.

You said that on 28 July 2017, you had questioned why the doctor completing your R35 Assessment had not completed the body map and the impact detention was having on you and the likely impact of continued detention. You said initially that the doctor had told you that the Home Office had told him not to complete these sections but when pushed that the Home Office knew doctors had not completed body maps for over 12 months and he, the doctor did not want to do the assessment on the affects of continued detention. You suggested that by not completing these two sections that the Home Office had taken a negative inference when they had completed his Rule 35 decision.

DR 01 said that ever since the HO workshop he attended in January 2017, prior to starting at Brook House IRC in February 2017, there had been an understanding that body maps added little and who made the assessment about continued detention *"vague."* He said the decision should be for the HO based on all areas and not just the doctor's assessment. On that basis, he did not complete body maps, feeling the listing of scarring as being as effective. He did not make an assessment about the impact of detention and by not doing so, the HO based their decision on the lack of comment meaning there was no impact. This was what he intended and what had happened in your decision. He said if there was an impact, he would complete a Part C (IS.91 form which is a risk assessment) for the detainee's release from detention.

He said that he might have said in passing to you that body maps are no longer required. DR 01 said he had not been asked by you or anyone why he had not commented on the impact of continued detention.

The policy on Rule 35 decisions, DSO 09/2016 Rule 35 defines torture as, 'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind.' It states that the Medical Practitioner (MP) 'shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture. The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.'

It continues that 'if the medical practitioner is concerned that a detainee may have been a victim of torture, they must submit a Rule 35(3) report. It is for the medical practitioner to decide if they have concerns in a professional capacity that a detainee may have been the victim of torture. The medical practitioner must always state clearly the reasons why they have concerns arising from the medical examination – specifically the medical evidence which causes these concerns, including all physical and mental indicators. Where there is medical evidence in support of an allegation, the medical practitioner must set out clearly all physical and mental indicators in support of their professional concerns. They must record any mental or physical health problems that are relevant to the torture allegation.

Where possible, the medical practitioner should say why they consider the person's account is consistent with the medical evidence. The medical practitioner should consider whether the injury, health problem or other indicator may have other possible explanations which do not relate to torture. The medical practitioner must identify any medical evidence which may or may not be contrary to the account given by the detained person.

Turning to the actual template report and the final assessment submitted by DR 01, this showed that he had written down the account as provided by you in Section 4. The next section asked for 'relevant clinical observations and findings and listed what was required. DR 01 mentioned the scars only. There was no request for a body map and no information provided by DR 01 regarding your medical history and the fact that there had been no mental health concerns up until the point of the Rule 35 disclosure.

The most concerning section was the assessment at Section 6. This asked for DR 01's 'reasoned assessment of why, on the basis of the detainee's account together with his own examination and clinical findings, he was concerned that the detainee may have been a victim of torture. There was a list of areas to address including 'impact detention is having on the detainee and why, including the likely impact of ongoing detention.' DR 01 chose not to address any of these. In terms of why he had objective grounds for his concern he stated 'his scars may be due to his account.' There was no assessment about the continued detention or anything else.

DR 01 said that the clarity about who made the decision about continued detention was a *"blurred line."* In his evidence he was quite clear that he did not feel that the decision about detention should be merely his and a clinical one. I was concerned about the lack of his comment being construed as an inference there was no concern. If so then just put it and take the 'mystery' out of it all.

The DSO on Rule 35 was very clear, as was the assessment form and instructions DR 01 had in front of him. It is acknowledged that DR 01 is making a number of these assessments daily and his reluctance about making a clinical assessment in case things changed, however that should not detract from the importance of the process or the individual before him. Medical Practitioners (MP) are asked for their clinical assessment because this is an essential part of the decision making process. DR 01, as a MP completing the Rule 35 assessment is required to give this and chose not to do so. I found that DR 01's assessment of you under Rule 35 was incomplete. It was unfair for DR 01 to assume that by not stating the impact of detention that an assumption of no impact would be made by the caseowner.

Likewise, I was concerned that the caseowner had not queried the missing information and had just made her own assessment on an assumption that no impact stated meant there was no impact on continued detention. I have recommended that this policy is reviewed and clarified between the Home Office and NHS England.

On the evidence and to a balance of probabilities, I find the allegation that Brook House officers informed the doctor not to complete his Rule 35 Assessment **unsubstantiated.** It was DR 01 who decided not to complete a body map and not to comment on the impact of continued detention and not Brook House officers or the HO as implied.

Allegation 6: that on 14 July and 07 September 2017, a nurse in healthcare had allegedly been rude to you, denying you access when the waiting room was not full and asking you to reveal medical details in front of other detainees.

Whilst the member of healthcare staff you described has not been identified, significant checks have been made with a Nurse who was present on 07 September 2017, Nurse 01. This was to check the process for detainees accessing the nurse clinic to determine if and when access would be denied, given it is a drop in facility.

Clinical Leads (CL) 01, 02 and Nurse 01 were consistent in their evidence that there is an open nurse clinic every day from 09:30-11:30 hrs. CL 01 provided a copy of the notice to detainees advising healthcare clinics and times. I was satisfied from this and your evidence that you were aware when you could access the nurse clinic.

You said that the door had been closed on 17 July 2017 and you had had to argue with the healthcare staff to open the door, given there were six seats and one of these was available so the clinic was not full as claimed by the nurse. You had also arrived within the allotted time (11:12 hrs). Your medical notes showed that you had actually arrived at 10:13 hrs, was seen by a nurse and requested a Rule 35 and a GP appointment was made for 24 July 2017. Nurse 02 had seen you on that occasion. She was an agency nurse and not available for the investigation. She did not match your description in any case.

Nurse 01 had not been on shift on 17 July 2017, but she outlined the process in the nurses clinic. She said that because there was no DCO in healthcare and detainees had been aggressive with healthcare staff there had been a risk assessment and a decision made that only six detainees should be in the clinic at one time; five seated and one with the nurse. The healthcare assistant would cover the door and as a detainee left another would be given access. The door might also be locked if healthcare staff had responded to an incident.

The evidence showed that the healthcare assistant had been following an approved process and was not being rude but managing the number of detainees in healthcare.

You also stated that the rude nurse had asked you why you had come to see the nurse and this had been in front of other detainees. Nurse 01 agreed that the specific health reasons should not be requested but the healthcare assistant would ask why the detainee was there to establish if the appointment was with the nurse, doctor, dentist or mental health team. The detainee could be late for their medication. Confidential information would only be discussed in the treatment room.

Again, the evidence showed that the healthcare assistant was asking a routine question to establish which professional you wished to see and not about your complaint, as she was required to do. It suggests that there was some miscommunication.

You consistently stated that you had not entered the nurse clinic or seen a nurse on 07 September 2017 and instead had been refused entry again at 10:55 hrs by the same nurse. You had become *"very angry and simply left to calm myself down."* You said that you had not seen the nurse or received any treatment.

Your medical notes showed differently. It was recorded by Nurse 01 at 11:47 hrs that you had seen her at 11:49 hrs complaining of stomach ache. You had not been happy to wait a week for a doctor appointment. She had advised Paracetamol in the interim but you had said you had taken this. The records had not shown this. An appointment slip had been given. You told me that Nurse 01 was lying because you had not seen the nurse.

Nurse 01 said that they had been *"way behind on appointments and no way could we make an appointment unless it was urgent."* She has assessed your stomach symptoms and that you could wait a week for your appointment. She said that you could take Paracetamol and if this did not work Ibrupofen. On reviewing your notes, she said that you had not taken any so she had advised you to do so. Nurse 01 said she could not write a note on the medical record without seeing the person. She had no reason to lie.

Both of you were adamant that the other was lying. I have taken into account that Nurse 01 was a trained nurse and had been at Brook House IRC for almost seven years and that a contemporaneous note had been entered on to your medical record. This note was about the condition you had complained about; stomach pain. I have also considered that you had been advised to take Paracetamol earlier that morning when Nurse 03 attended a call to your room and Nurse 01's comment that you had

said you had but this was not recorded. On the evidence and to a balance of probabilities, I find the allegation that on 17 July and 07 September 2017, a nurse in healthcare had been rude to you, denying you access when the waiting room was not full and asking you to reveal medical details in front of other detainees **unsubstantiated.** The healthcare assistant appears to have been following the prescribed process.

Allegation 7: that on 13 September 2017, you were allegedly spoken to very rudely by DCO Bonnie Spark during the lock up for the evening mealtime.

You said that DCO Bonnie (DCO 07) had spoken to you *"very rudely"* being told *"just get back into your room now…don't do that anymore you saw me and you went away…that's the last time. I told you that's the last time. If you saw me you don't walk away."* You said that you thought DCO 07 had thought you had walked away intentionally but you had been speaking to your solicitor and had moved for a better signal. She had not listened to you when you had tried to explain. You had asked a female DCO (DCO 08) to tell DCO 07 not to speak to you like a child and DCO 07 had said *"get in right now. Get in right now."* You had said you knew you had to get in your room for lock up but DCO 07 could have said please.

DCO 07 could not remember the incident and said she worked predominantly in Reception. She said this had been the week after Panorama aired so officers were covering every wing. She denied that she had been shouting at you, given this could have caused you to raise your and things would then have escalated. She was also professional and had been a DCO for four years.

DCO 08 had been present at roll count and said how they had to get all detainees in their rooms by 17:00 hrs for roll count. She said how detainees had continued playing pool, or went for a shower instead of doing this. She said how DCO 07 had told those playing pool and you (on the phone) to get into their rooms. DCO 08 remembered you being *"mad at her (DCO 07), said something and they exchanged words...both were firm with each other…both hitting off each other. One was asked to do something the other did not want to do it. There probably should have been more negotiating."* DCO 08 said DCO 07 *"sometimes can be a little rude in her comments, very direct…because she is young* D668 *may have expected more respect."*

Although the roster showed both DCOs on B and not D Wing (and DCO 08 was certain it was B Wing where the incident occurred) the evidence of DCO 07 was that they were covering all wings. You were definitely on D Wing so it would be reasonable to assume that the incident happened on D Wing as you alleged. Both DCOs had been on duty in Brook House IRC.

The evidence showed that some of the detainees were refusing to return to their rooms, two DCOs were attempting to deal with this and it was nearly five o'clock. It is acknowledged that it could be frustrating for a DCO if detainees were ignoring requests to return to their rooms, an event that happened four times a day, however DCOs are trained to remain professional. I have accepted that you had a legitimate reason for his slight delay (phone call) however the centre rules are that everyone

should be in their rooms by 17:00 hrs and this involves over 100 detainees to two officers. You were aware of this.
DCO 07 was repeating her instruction and you were justifying your delay in response. The Violence Reduction Strategy provides guidance to staff on how to deal with verbal behaviour. It states, 'asking someone who is agitated or being aggressive to behave in particular way can be testing. Repeating requests in a calm and assertive way, even raising your voice, if necessary, is often very effective.' DCO 07 was entitled to do so to deal with you given you were, according to DCO 08 very angry.

However, when this was not effective and from DCO 08's evidence it had become an argument rather than a request then DCO 07 should have followed guidance and tried to negotiate to de-escalate the situation. The guidance states, 'negotiation refers to the process of communication and involves bargaining, give and take, trading-off, and generally trying to reach some sort of compromise, whilst avoiding excessive conflict.' DCO 07 did not.

I have taken into consideration that DCO 07 has been a DCO at Brook House IRC for nearly four years and was primarily based in Reception and only covered the Wings, however she was a certified DCO and as such would be aware of her responsibility to detainees and the professionalism required. G4S Human Resources said that there were no misconduct issues relating to DCO 07. On the evidence and to a balance of probabilities, I find that DCO 07 did speak to you very rudely during the lock up for the evening mealtime. She should have handled the situation more professionally and used the tools available to her. The allegation is **substantiated.**

Allegation 8: that on 16 September 2017, you attended a meeting with the care officer and a form was filled in about your complaints. You indicated you did not feel safe in Brook House IRC but had received no feedback so you felt neglected and that G4S officers did not care.

In our interview, you submitted a copy of the Care Officer Monthly Review form that was incomplete as it did not state the officer's name, the date and monthly review number. The information about your problems was scant in that the female member of staff was not named but you told me that you had given the name Bonnie. It was clearly marked 'no' about you feeling safe in the centre and listed Spice, detainees fighting and an incident in the gym when your friend had been threatened. It also said some staff had no respect for detainees. You said you had had no response to these concerns after raising them directly with an officer.

From your description and your G4S database record, DCO 09 was identified as the officer who had completed this review. She said that she conducted these daily with many detainees but was unable to remember this one with you. She said that if she had any concerns then she would raise these with managers. DCM 03 was on the roster and a witness statement was requested. He is currently suspended and had not provided this at the time the report was completed.

However, the G4S database record showed DCO 09 had escalated this concern to DCM 04 who was the Oscar 1 on 16 September 2017 and not this manager. This

suggested that she had significant concerns about the issues raised by you but she must not have followed up these concerns given she provided no feedback to you.

DCM 04 said that he could not remember whether he had or had not helped you and said what he would have done if this had been raised to him. There was no note on the G4S database to say what if any, support had been offered to you. This showed that even after you had said you felt unsafe and provided your reasons for this, nothing was done with your complaint. You were an adult at risk as identified by the Rule 35 decision dated 25 July 2017. The actions of G4S officers were not those of support.

Both DCO 09 and DCM 04 breached the Violence Reduction Strategy that states 'all complaints and grievances will be listened to and not dismissed out of hand. Detainees or Visitors to Gatwick are able to report concerns at any time even when they have left the Centre. All reports will be taken seriously and dealt with promptly and appropriately. Confidentiality will always be assured, but should circumstances change this, then it will be explained. Detainees will always be given feedback on how the issues have been dealt with.' They did dismiss it out of hand and provided no feedback.

On the evidence and to a balance of probabilities, I find that the allegation that on 16 September 2017, you attended a meeting with the care officer and a form was filled in about your complaints. You indicated you did not feel safe in Brook House IRC but had no feedback so felt neglected and the G4S officers did not care **substantiated.**

Allegation 9: that on 26 or 27 September 2017, items were stolen from your room in your absence. When you spoke to the Wing manager you were told an investigation would take place but nothing happened and you felt angry that this behaviour had been sanctioned and you had received no reassurance this would not happen again.

When we spoke, you were unable to identify the Wing manager you spoke to but a process of elimination has tied this to DCM 05 who was on duty on 27 September 2017. DCM 05 cannot remember being told about the incident or conducting any investigation. There was no observation on your G4S database record or any IR or SIR reports submitted. No CCTV was available, given the time since the incident.

Given there were no records for the event on 12 August 2017 or after you had made a previous complaint on 16 September 2017, I have placed more weight on your evidence. On the evidence and to a balance of probabilities, I find on 27 September 2017 items were stolen from your room in your absence and although you spoke to the Wing manager and was told an investigation would take place nothing happened and you felt angry this behaviour had been sanctioned and you had received no reassurance this would not happen again **substantiated.**

Allegation 10: that the IT system in Brook House IRC is so bad that it made it difficult for you to send emails to your lawyers.

Residential and Regimes Manager (RRM 01) said that the internet system had been down for four days in September 2017 due to an external line problem. Virgin and BT

were called to fix the problem. He said that detainees would of been notified of this, as posters would had been put up on the doors in the IT rooms, explaining to detainees that if they wish to get access to their accounts or print in regards to their cases then provisions such as going to welfare or see one of the residential DCMs who would have access to internet.

He said that detainees could print from the IT room, unless the printer was not working or not connected to the individual computer because it was replaced following continue damage to individual computer's by detainees and not connected. Plans had already been in place to refurbish the IT before this issue in September 2017. He said one of the other issues detainees had, was not being able to open their attachments, again because of the system it didn't allow this to happen on certain sites. He said if a detainee wanted to print out an email with attachments and could not print in the IT room, he would have to go to Welfare first.

There is only one central welfare office, although staff do deal with welfare issues on their own wings on a daily basis, but don't print. Outside of welfare this can be done by the residential DCM. He said that to access Welfare a detainee would have to queue as there were only one or two members of staff. The waiting time would be dependent on the needs of the detainees being seen at the time. In September 2017, 1064 detainees used Welfare and this equated to 35 detainees per day or five detainees an hour. He said Welfare was available 08-11:30 hrs, 13:30-16:30 hrs and 18:30-20:30 hrs; a total of seven hours a day. This met the minimum requirement of five hours as stated in DSO 07/2013. He said that detainees had access to a fax machine and there was one on each wing.

IT was completely refurbished in October 2017 due to the continue damage by detainees and having access to sites which they were not allowed to have because of the firewall. Sir Stephen Shaw in his review of detention centre said 'unlike prisoners, detainees have permanent access to a mobile phone and enjoy restricted access to the internet. The question for me is whether welfare needs would be better met through a reduction in the current restrictions on internet use, subject to necessary risk assessments.' He said that detainees 'argued that access to the internet was inappropriately limited, with detainees not able to access information relevant to their cases.' He recommended that 'the internet access policy should be reviewed with a view to increasing access to sites that enable detainees to pursue and support their immigration claim, to prepare for their return home, and which enable them to maximise contact with their families. This should include access to Skype and to social media sites like Facebook.' Some of this was done with the Access to Internet DSO 04/2016.

In this, it said 'each centre must ensure that internet access enabled computer terminals are available to detainees 7 days a week for a minimum of 7 hours a day, though individual time slots may be limited if there is excessive demand.' There is nothing about what should be done if the internet is suspended through an outside force i.e. internet provider as in this case. It does however state 'If a detainee has their access suspended and requires access to the internet for material relevant to their immigration case the detainee can approach the IRC's welfare office who will provide limited supervised access on a case by case basis.'

Whilst not an ideal situation, Brook House IRC were at the mercy of the internet provider and the provision of internet was therefore outside of their control. The Welfare office was available to detainees and I was satisfied that there were alternative means of communication, mobile phones and fax machines at your disposal.

On the evidence and to a balance of probabilities, I find the allegation that the IT system at Brook House IRC was so bad that it made it difficult for you to send emails to your lawyers **part substantiated**, given you had alternate means of communication.

Allegation 11: that the toilet facilities in your room were inadequate and lacked privacy (causing you humiliation when using during times when your room was locked).

I noted how extremely distressed you were when describing the toilet facilities in your room and your use of this, given you shared a room and was locked in this room at certain times during the day and all night. You said there was no cover and the toilet area was open. The window was fastened shut so there was no ventilation and there needed to be because of the smell. Your bed had been opposite the toilet and you cried when your roommate used the toilet because of the smell. You had to lie there and smell it. You would not use the toilet during lock ins because it was humiliating and you hurt his stomach by keeping it in. You said there was no seat and the toilet was filthy and had never been cleaned; brown inside. You had to stand to use it and would not sit down on the dirty seat. You said all of this had been like torture and had affected your mental health.

The toilets in the rooms in Brook House IRC were viewed. They had a curved wall (to prevent ligatures) and a sheet of velcroed material across the doorway. G4S said that some of these curtains were previously missing but have since been replaced. There were two complaints about the toilets between April and June 2017. It was acknowledged that sharing a room with two detainee, with one toilet in the room, could cause discomfort and be unpleasant although the Home Office accepts this as an operating norm. The Operating Standards for IRCs state for hygiene 'the Centre must ensure that detainees have access to toilet and hand washing facilities 24 hours per day.'

During Sir Shaw's visit to Brook House on 22 June 2015 he noted, 'the toilet/shower was separated from the room by a curtain.' The norm, especially in new-build facilities, such as on the Heathrow estate and at Brook House, is for lock-in between 9pm and 8am (though, at Brook House, for example, detainees are also locked in their rooms for half an hour at noon and 5pm for roll call).'

He found that 'there is no evidence to suggest that any of the accommodation viewed in the IRCs and other detention facilities has not been certified as fit for use in the terms of Detention Centre Rule 15, or that regular checks on the accommodation are not being carried out. The nature of the accommodation varies across the estate. Much of it is decent but some rooms are less pleasant. Apart from the example mentioned above (Colnbrook), the policy requirements in terms of

hygiene appear to be being met.' Sir Shaw made no recommendations about the toilet facilities in Brook House IRC.

Rule 15(2) of the Detention Centre Rules 2001 provides that 'No room shall be used as sleeping accommodation for a detained person unless the Secretary of State has certified that:- (a) its size, lighting, heating, ventilation and fittings are adequate for health'. DSO 04/2003 (re-published January 2017) has been issued 'to ensure that all accommodation provided at immigration accommodation centres is compliant with Detention Centre Rule 15 and published Operating Standards'. The DSO provides that for rooms with no natural ventilation, 'the minimum fresh air rate must be eight litres/second/person where no smoking is permitted' and where smoking is permitted 'the fresh air rate shall be increased in accordance with CIBSE Guides and the Building Regulations Part F1 recommendations.'

Checks with the contract monitor at Brook House recorded that 'in August 2016, the Secretary of State certified that the rooms in Brook House 'are of such size and are lighted, heated, ventilated and equipped in such as a manner as is requisite for health.' I understand that there is a wider HO review of accommodation facilities at Brook House IRC and your concerns have been raised to this review as promised at interview.

D668 evidence about the toilet was that he was upset and humiliated about the state of the toilet and having to use this in front of a roommate and to be subject to being present when the roommate used this. I understand that the responsibility for cleaning the toilets falls to the detainees themselves and cleaning products are available. Other than that, the toilet in the room, room sharing and lock up are an accepted norm by the HO at this time and no issue has been raised in the centre-wide review by Sir Shaw. Current HO policy is that you need only have access to a toilet and you did. On the evidence and to a balance of probabilities, I find the allegation that the toilet facilities were inadequate and lacked privacy **unsubstantiated** unless found otherwise by the wider HO review.

In conclusion, you raised 11 allegations ranging from inappropriate conduct by staff (DCM 01 and DCO 07) to officers ignoring complaints and providing insufficient feedback on any complaints you raised. You only ever raised verbal complaints and never used the HO complaints mechanism. You said that you had only ever submitted one complaint to the G4S complaint box in the library in August 2017. This was next to the HO complaints box. The form you had completed had been in the library. You received no response from G4S so did not use the formal complaints process again. You had not used the HO complaints process because a friend of his had and was then removed.

I conducted checks with Brook House IRC to ensure that there was only the HO complaints box as there should not be and not a separate G4S complaints box. They confirmed that there was only the yellow Immigration Enforcement Complaints box and this was on each Wing. In the library there is a grey Samaritan's box and a red Immigration Enforcement box labelled complaints and requests. There is no box with a G4S sign on it. The Detention Centre Form (DCF) 9 advises the detainee to place the form in the yellow box. G4S are copied in on the complaints that are sent to

Detention Services. G4S provided the list from August 2017 and there were none from you.

Of the 11 allegations, I have found six unsubstantiated, four substantiated and one part-substantiated.

Turning to your policy issues on the guideline issued to G4S and HO staff on what to do if a detainee raises the fact that Spice is being used in the centre….on the Rule 35 assessment and who makes the decision regarding continued detention, the accommodation (DSO 04/2003) including the toilet facilities and the time that detainees are locked up and any breaches to Articles 3, 5 and 8 in respect of the conditions at Brook House IRC and the lock up……..

Feedback on how the HO are monitoring how G4S are attempting to control how drugs come into the centre…

Yours sincerely

Helen Wilkinson
Investigating Officer
Professional Standards Unit
Enc: PPO leaflet